0277
1 SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS: CIVIL TERM: PART 19
2 -X
JEANETTE LICITRA,
3 Plaintiff,
4 INDEX NUMBER:
- against - 12935/06
5 TRIAL
6 CHARLES M. LOMBARDI,
Defendant.
7 -X
8 General Courthouse
88-11 Sutphin Boulevard
9 Jamaica, New York 11435
10 April 23, 2010
BEFORE:
11
HONORABLE PATRICIA P. SATTERFIELD,
12 Justice of the Supreme Court
(And a Jury)
13
APPEARANCES:
14
GARY B. PILLERSDORF, ESQ.,
15 Attorney for the Plaintiff
225 Broadway
16 New York, New York 10007-3001
BY: GARY B. PILLERSDORF, ESQ.
17
18 HEIDELL, PITTONI, MURPHY & BACH, LLP
Attorneys for the Defendant
19 1050 Franklin Avenue
Garden City, New York 11530-1760
20 BY: ANTHONY M. HELLER, ESQ.
21
22
23
24 MICHELLE SHEEGER, MARY BENCI
SENIOR COURT REPORTERS
25
0278
1 (Whereupon, Plaintiff's Exhibit 10, Dr. Martin's chart was
2 marked in evidence.)
3 (Whereupon, Plaintiff's Exhibit 11, Dr. Aglietti's chart was
4 marked in evidence.)
5 (Whereupon, Plaintiff's Exhibit 12, Dr. Gudeon's chart was
6 marked in evidence.)
7 (Whereupon, the jury entered the courtroom.)
8 THE CLERK: Both sides stipulate the jury is
9 present and properly seated?
10 MR. PILLERSDORF: Yes.
11 MR. HELLER: Yes.
12 THE CLERK: Thank you, you may be seated.

13 THE COURT: Welcome back.
14 You may call your next witness.
15 MR. PILLERSDORF: I call Dr. Douglas Stabile.
16 D O U G L A S E D W A R D S T A B I L E,
17 called as a witness by and on behalf of the Plaintiff
18 having been first duly sworn, was examined and testified as
19 follows:
20 THE CLERK: State your name and business address
21 for the record.
22 THE WITNESS: Dr. Douglas Edward Stabile,
23 S-T-A-B-I-L-E 1721 Financial Loop Lakeridge, Virginia.
24 THE COURT: You may inquire.
25 DIRECT EXAMINATION

1 BY MR. PILLERSDORF:
2 Q Doctor, could you tell the jury your occupation?
3 A I am a podiatric physician.
4 Q You are so licensed?
5 A Yes, sir.
6 Q Let's do a little bit about your educational
7 background. Could you tell us where you went to undergraduate?
8 A Well, actually I went to undergraduate two years at
9 Harrisburg Community College; and I graduated from Millersville
10 State College at Millersville, Pennsylvania with a bachelors of
11 science in biology.
12 Q Where did you go to podiatric school?
13 A The podiatric school I attended was in Philadelphia, at
14 that time it was called the Pennsylvania College of Podiatric
15 Medicine, now it's been re-affiliated with Temple University, so
16 it has a different title, Temple University Podiatric Medical
17 College.
18 Q What year did you graduate from podiatric school?
19 A In 1985.
20 Q We actually heard yesterday that Dr. Lombardi went to
21 the same school and graduated in '82, did you know him?
22 A No, I didn't know him, that I remember.
23 Q A lot of people there?
24 A Yes.
25 Q Good enough.

1 Following your graduation from the medical school did
2 you do a residency?
3 A Yes, I did.
4 Q Was that a surgical residency?
5 A I completed a two year foot and ankle residency in St.
6 Louis Missouri Lindel Hospital was the name of the hospital,
7 it's now a rehab hospital.
8 Q During that time were you the chief resident as well as
9 a regular resident?
10 A In my second year of training I was chief resident.
11 Q Do you hold board certifications in the field of
12 podiatry?
13 A I do.
14 Q What are your board certifications in?

15 A I am board certified by the American Board of Podiatric
16 Surgery.
17 Q To become board certified in the American Board of
18 Podiatric Surgery what does one have to do?
19 A After you are in private practice, there's no really
20 time limit, you have to accumulate a certain number of different
21 procedures. For example, in foot surgery some of you might be
22 familiar with, there's bunion, hammer toe, heel spur, there's
23 different categories of surgery. After you accumulate a certain
24 number they have categorized you apply for board certification.
25 Then you go and take an examination, it's typically a
0355
1 two day oral exam, and a two day written exam. And if you pass
2 those successfully you become board certified.
3 Q That's a national board everyone all over the country,
4 everyone that's board certified takes the same exam and same
5 requirements?
6 A All 50 states, correct.
7 Q And you are also a fellow in the American College of
8 Foot and Ankle Surgeons, what is that?
9 A That's an organization that's primarily based to
10 increase education and knowledge of podiatric medicine and
11 surgery for the podiatric physicians.
12 And to become a fellow you have to apply, and typically
13 you become board certified, then the fellowship goes along with
14 that.
15 Q Have you held faculty positions in podiatric medicine?
16 A I've never been a faculty member in any of the
17 colleges, I've held training positions. I am involved with the
18 residency program in Fairfax, Virginia. Some of you may of
19 heard of Fairfax Hospital, it makes the news at times, pretty
20 big facility.
21 So I am considered an attending physician, and had
22 actually been involved at times with the residency training
23 committee giving lectures and helping the residents. And they
24 also have students that come from the different podiatry schools
25 that will perform an externship, they'll spend one month with us
0356
1 and see us in the hospital and help teaching and in an office.
2 Q What are the current affiliations you have now, where
3 do you practice?
4 A I am in private practice in Lakeridge, Virginia which
5 is about 20 miles south of Washington D.C. I started the
6 practice in 1989, and I grew to two offices in '94. Currently
7 we have four doctors and we're adding number five.
8 Q Are you affiliated with any hospitals or have you been
9 affiliated with any hospitals?
10 A Throughout my career in Virginia I have been associated
11 with several hospitals. Currently I am on staff at the Fairfax
12 Hospital which I mentioned earlier; another hospital is called
13 Potomac Hospital and Stafford Hospital in Stafford, Virginia.
14 Q You've also been at Mary Washington Hospital; is that
15 correct?
16 A Yes, I have. I have been on staff there.

17 And then what's happened most recently, we've changed
18 our status, which is just to update the CV we're primarily
19 associated with Stafford Hospital which is close to there too.
20 Q You belong to any professional societies?
21 A I am a member in good standing of the American
22 Podiatric Medical Association, which is a national organization
23 to help promote podiatry and an organization to educate; also I
24 am a member in good standing of the Virginia Podiatric Medical
25 Association. And in the state of Virginia they divide it in

0357

1 northern and southern, and I am also a member of the northern
2 Virginia Podiatric Medical Association.
3 Q Doctor, you maintain a full-time private practice?
4 A Yes.
5 Q And what type of procedures, what does your practice
6 encompass?
7 A It's a -- I would consider it a mix of surgical and
8 nonsurgical podiatric care, so as I expressed earlier I am
9 involved with hospital cases where we do surgeries such as
10 bunion correction; heel spur surgery; ankle fracture repair;
11 you've might of heard of athletes that will tear their Achilles
12 tendon.
13 And then we also do surgical care, for example, for
14 people with arthritis and diabetes; sports related athletes.
15 And then in the office we'll do medical care, for
16 example, you might be familiar with people with diabetes have
17 severe -- have complicated problems, and so we do a lot of
18 preventive care in people with bad circulation and diabetes.
19 And all ages too, a lot of sports related medicine in
20 our practice too.
21 Q You do actively engage in surgery; is that correct?
22 A Yes, Wednesday -- pardon me, Wednesdays in my practice
23 are my surgery day and in a typical week we can average anywhere
24 from two to five surgeries each Wednesday, depending on the
25 cases involved.

0358

1 Q And you are familiar with tendon repair, lateral tendon
2 repair of the ankle, you've done these types of procedures?
3 A Yes.
4 MR. HELLER: Objection, we're beyond minimal
5 foundation, can we stop leading now?
6 THE COURT: Rephrase your question, counselor.
7 Q What experience do you have with surgeries of the ankle
8 with regard to the tendon, more specifically to the tendons?
9 A Well, as I mentioned earlier, actually in our state our
10 scope of practice includes tear of the ankle and the foot, so
11 any of the tendons related to the ankle, for example, like the
12 Achilles tendon, which is the tendon on the back of your leg, or
13 actually any of the tendons, if they are damaged or ruptured or
14 injured we do surgical repair, if it's necessary.
15 Q Have you had personal experience with peroneal tendon
16 repairs?
17 A Yes.
18 Q Now, along with your private practice do you from time

19 to time do consulting with regard to medical/legal items?
20 A I do.
21 Q Could you tell us a little bit about that?
22 A Well, interesting, when I first started private
23 practice in 1989 in Virginia I was involved with several
24 actually defense related cases where there were physicians in
25 the state --
0359
1 MR. HELLER: I will object to this. Can he ask a
2 question that's restricted to something in particular?
3 Q Tell us about your experience in medical/legal
4 examinations and evaluations?
5 A Succinctly I would say the last ten to 12 years I have
6 been involved with medical expert testimony in both defense and
7 plaintiff cases.
8 Q Now, this type of case evaluations, are you listed with
9 any group, or how does one find you if a plaintiff or defendant
10 attorney needs an expert or a consultant, how would one find
11 you?
12 A Well, different ways that I get referred legal matters
13 for my review. I am listed, and I do pay for my name to be
14 listed, in two services, one's called SEAK, and ALM Experts,
15 those are two that recently I am a member of. And there's
16 hundreds of medical and even nonmedical experts in these
17 referral services, so that if you were looking to have a foot or
18 ankle specialist review a potential malpractice case your name's
19 listed.
20 Also I get referred from other lawyers that I have been
21 involved with with cases, and I know that lawyers can look and
22 see favorable outcomes with other cases, and they will choose to
23 work with medical experts that have had those results.
24 Q What percentage of your practice would you say is
25 involved in the medical/legal field?
0360
1 A I think a better way to answer that, the best way to
2 answer that, is what percentage of my income is from medical
3 expert work and it is --
4 MR. HELLER: Objection to the response, your
5 Honor. It wasn't the question. It may be what he wants to
6 tell us about.
7 THE COURT: Answer please.
8 A Five percent of my personal income at most is from
9 medical expert testimony reimbursement.
10 Q In this particular case, Shafran and Mosley, do you
11 know how they came to get in contact with you?
12 A There was a -- there's a referral service, if I am
13 correct, it's called Medical Advisors, I think they are near
14 Philadelphia, and they contacted me to see if I would be
15 available to review the case involved.
16 Q And what's the procedure, in other words, if a lawyer
17 requires a physician to help them decide if there's a case, if
18 they want to get involved, the procedure that's followed when
19 they contact one of these review companies, what does the review
20 company do with you?

21 A The review company contacts me and they'll give me just
22 superficial information about the case, they'll tell me where
23 the case is located, and who the doctor and plaintiff are to
24 make me aware of whether I might know the doctor or not.
25 And then if I -- typically, if I know the doctor I
0361
1 choose not to be involved with the case, but then they'll
2 contact the attorneys and then the attorneys will send me the
3 records for my review.
4 Q In this particular case you were sent documents?
5 A Yes.
6 Q The original law firm sent you the documents that were
7 available at that time?
8 A Yes, sir.
9 Q And you reviewed those?
10 A I did.
11 Q Among the items that you reviewed were the hospital
12 record --
13 THE COURT: Why don't you tell us what you
14 reviewed?
15 Q You have a list there or do I have your list?
16 A I can recollect, and Mr. Pillersdorf can help me if I
17 misspoke, I had the opportunity to initially review the medical
18 records of Dr. Lombardi's treatment of Jeanette Licitra,
19 including the Flushing Hospital records of the operative
20 scenario at the time that she was in the hospital and had had
21 the operation; and Dr. Applebaum's evaluation, physical therapy
22 notes, I think the name of the organization -- the physical
23 therapist was Maspeth; as well as Dr. Caprarella and Dr.
24 Gazzaniga, correct me if I am wrong with the pronunciation. I
25 have had the chance to review those as my initial evaluation of
0362
1 the case.
2 Q Subsequent, as other records became available, did my
3 firm in fact send you more updated records?
4 A Yes, sir.
5 Q You've had the opportunity to examine some of the
6 records of her prior treating physicians, her prior treating
7 podiatrists?
8 MR. HELLER: Your Honor, this is leading again.
9 THE COURT: Overruled.
10 You may answer.
11 A I was provided records from a Dr. Martin who had
12 provided treatment to Ms. Licitra before her seeing Dr.
13 Lombardi.
14 I don't know -- I can't recall or recollect any other
15 treating podiatrist before that time.
16 Q Were you also given various legal documents to look at,
17 depositions, what have you?
18 A As they occurred, yes.
19 Q So you've had a chance to review all the material?
20 A I reviewed everything provided to me, correct.
21 Q If you could, doctor, now before we get into it, get
22 into this particular case, could you tell us a little bit about

23 anatomically the tendons that we're talking about and the
24 anatomy involved in this case? We have various diagrams.
25 A Any of those are fine.
0363
1 Q I will give you this one. (Handing.)
2 Doctor, can you come down?
3 THE COURT: You may step down.
4 A Can everyone see this fine?
5 Q Could you just give us a short lesson on the anatomy
6 that we're dealing with and the function of the different parts?
7 A The nerves in our body actually have three functions,
8 one, to make our muscles move, that's called motor or movement;
9 two, they give us sensation; and number three, the nerves
10 affect circulation.
11 In this particular case the nerve damage or injury is
12 related to what's called the common peroneal nerve --
13 Q You can put it up.
14 A Pardon me.
15 Q And the doctor's now referring to Exhibit 7,
16 Plaintiff's Exhibit 7.
17 A The nerves come down your spine and forms your spinal
18 cord. Your spinal cord, and down each leg goes the sciatic
19 nerve. Sciatica nerves, the sciatic nerve goes around your back
20 side, down your leg to the back of your knee. Half the nerve
21 goes down the back of your leg, and half comes around the front
22 of your knee by the long bone here, which is called the fibula.
23 The head of the fibula is the top of the fibula. Below
24 the head it's skinny, like my arm, and the nerve goes around
25 that.
0364
1 Q Doctor, we have a skeleton here, if it's of any help.
2 A Pardon me.
3 So the nerve comes down here and it wraps around right
4 on top of the bone, and then it goes down in between the
5 muscles. That nerve splits into two nerves, one's called the
6 superficial peroneal nerve, which is mostly sensation like I
7 talked about the one that feels the skin; and the other one is
8 called the deep peroneal nerve, that's the one most involved
9 with how the muscles move the foot.
10 Q Just note the exhibit, Exhibit 4.
11 A The nerve that's shown here, the muscle or brown
12 tissue, this is the common peroneal nerve. The reason they call
13 it the common peroneal, it has that name before it splits into
14 the two that we talked about. That's right below your knee.
15 The deep peroneal nerve affects the muscles in the --
16 most of the muscles in the front. The three main muscles in the
17 front of your leg are the tibialis anterior muscle, which is the
18 one that comes down and actually goes on the top inside of your
19 foot to help your foot come up and in; the extensor digitorum
20 muscle which makes your toes go up and down; and extensor
21 hallucis, which the term for big toe.
22 When you have muscle weakness, if the nerve is damaged
23 that makes the muscles move, it won't make the muscles move,
24 it's sick. So what happens, the common peroneal nerve, if it

25 gets damaged or if there's any condition that affects it, that
0365
1 changes the way that your foot works.
2 So the pertinent information, I think, related to this
3 case is understanding that that nerve, unfortunately, is very
4 close to the skin and very exposed. There's no muscle over the
5 top of it here, and right where it goes around the top of
6 that -- the head of the fibula, it doesn't take much to pinch
7 it.
8 Q Before we move on, I appreciate the nerves, if you
9 could, if you could interrupt the nerve discussion for one
10 second. We know that the underlying surgical procedure dealt
11 with the tendons?
12 A Correct.
13 Q Could you explain, before we even get to what went
14 wrong, what went right, what was the problem with this patient?
15 A On the side of our leg, starting at the knee, there's
16 two muscles that run along the side of your leg, they are called
17 peroneal muscles. So together they are called peroneal muscles,
18 individually they are called the peroneus longus and peroneus
19 brevis, and those muscles help to stabilize your muscle and help
20 with movement of your foot and leg; they help you with side to
21 side motion, like if you're a tennis player; and help you going
22 up and down stairs, because they have power to help you move
23 your foot.
24 And in Mrs. Licitra's case the peroneus brevis was
25 damaged right around the ankle area with tears. And Dr.
0366
1 Lombardi identified that first with an MRI, and he found there
2 was some damage to the tendon, and surgically went in, and in
3 his operative report talked about tears in the tendon that he
4 repaired and that's what she had done.
5 Q I will ask you to resume the stand, I want to go
6 through some of the operative report and preoperative notes.
7 THE COURT: While he is taking the stand, counsel,
8 please approach.
9 (Whereupon, discussion held off the record.)
10 (Whereupon, the witness resumed the witness stand.)
11 Q Doctor, let's talk about this tendon injury that was
12 diagnosed by the physician. You have reviewed the records. In
13 here, he is referring now to Plaintiff's Exhibit 2 on the
14 doctor's notes, he indicates his impression that it's a probable
15 longitudinal tearing of the peroneal tendons left foot causing
16 effusive form of swelling along the lateral aspect of the ankle.
17 Then he talks about the IPK's, which we were told are just
18 callous problems, right?
19 A Correct.
20 Q His impression of probable longitudinal tearing of the
21 peroneal tendons, that was the working diagnosis that he had
22 reached?
23 A Yes.
24 Q You have read over that; is that correct?
25 A Yes.
0367

1 Q He then sent the patient for the MRI, have you looked
2 at the MRI records?
3 A I did.
4 Q The MRI, could you tell us what the MRI found?
5 A The MRI record said that there was tendinosis.
6 Q What does that mean?
7 A That there's some inflammation around the tendons. An
8 MRI -- I don't know if everyone's seen an MRI, it's more like a
9 radar picture than an actual photograph -- you can tell
10 something's wrong, but sometimes you can't see exactly. And as
11 Dr. Lombardi knows, at times the MRI says things are fine and
12 there's a tear, meaning a long tear that you can't see, or
13 sometimes it's read as being a big problem and it's less of a
14 problem than you thought.
15 Q Doctor, I am removing from Exhibit 1 --
16 THE COURT OFFICER: No, 2.
17 MR. PILLERSDORF: Your Honor, there are two yellow
18 tags on it, that's the problem.
19 Q -- from Exhibit 2 the MRI report. I just need the top
20 two pages.
21 Can you show the jury what the MRI looks like, at least
22 a reproduction of it.
23 A As I mentioned earlier, you can see it's not a distinct
24 photograph type picture, it's more like a shadow, or even a
25 radar picture.

1 And what they are showing here, when we see fluid, the
2 white is -- could be water or fluid you can say, and so fluid
3 along the tendon's not supposed to be seen. If there's
4 inflammation and swelling you will see it.
5 So as the radiologist wrote in his report peroneal
6 tendon tenosynovitis with tendinosis of the peroneus longus.
7 MR. HELLER: He is reading from the exhibit, I
8 think you have to read all the words in that sentence, so
9 it says tendinosis slash tendinopathy, doctor.
10 A Peroneal tendon tenosynovitis with tendinosis slash
11 tendinopathy of peroneus longus.
12 MR. HELLER: Thank you.
13 Q What do they go on to say, does the MRI, according to
14 the radiologist who reads it, is there any indication on the MRI
15 of a tear?
16 A No.
17 Q So from the MRI now is the tear a clinical finding or
18 is it one that the MRI should confirm if it's there?
19 A Well, as I stated earlier the MRI isn't perfect, so at
20 times the tear could be present and we can't see it or sometimes
21 it is even read as a tear, we open it up and it's not torn.
22 Q Doctor, based upon the findings that we saw on June
23 20th in the doctor's report, and this MRI and the MRI report
24 which was taken on July 6th and then -- actually taken on July
25 6th, do you have an opinion as to whether surgery would be the

1 only method of treating this problem?
2 A Well, without the -- well, with reading the MRI

3   diagnosis you could have -- you could give the option for a
4   patient to undergo bracing, physical therapy, even cast
5   immobilization before you decide on surgery.
6   Q   Now, you said bracing, physical therapy or cast
7   immobilization?
8   A   Correct.
9   Q   Those are three possibilities?
10   A   I think those are three good options.
11   Q   And that's based on the findings on the 20th and the
12   MRI?
13   A   Right.
14   Q   Now doctor, you were supplied, in fact we looked at it
15   this morning because they are in evidence now, some of her
16   earlier, earlier podiatric records; is that correct?
17   A   Right.
18   Q   One of them was from a doctor which is now Exhibit 11,
19   a podiatrist that she saw --
20   MR. HELLER: Your Honor, can we approach, please?
21   THE COURT: Approach.
22   (Whereupon, discussion held off the record.)
23   Q   Doctor, historically from your review of the records,
24   referring to Exhibit 11, the patient has had problems with the
25   peroneal tendon before?

1   A   In the past, correct.
2   Q   They have resolved before?
3   A   The record I reviewed she had a problem that appeared
4   to resolve within a few weeks after treatment.
5   Q   In any event, it was decided by the doctor to do the
6   surgery, correct?
7   A   Correct.
8   Q   And that's the doctor's opinion to do the surgery; is
9   that a fair statement?
10   A   Absolutely.
11   Q   You have read his surgical record?
12   A   I did.
13   Q   With regard to the actual procedure are there any
14   problems that you have observed with the procedure?
15   A   No, I thought it was indicated, and according to the
16   documentation and the operative report it was performed
17   correctly.
18   Q   Now, once the procedure is completed we now have the
19   immediate postoperative care; is that correct?
20   A   Yes, sir.
21   Q   Doctor, yesterday with Dr. Lombardi we went through a
22   timeline. You have the operative records in front of you?
23   A   I do.
24   Q   I don't mean yours, if you can look at the real chart?
25   A   Yes, sir.

1   Q   You have seen these before, is that right?
2   A   Yes.
3   Q   You've had the opportunity to review these before?
4   A   Yes.

5 MR. PILLERSDORF: Your Honor, may I write on the
6 back of one of these?
7 THE COURT: You may.
8 MR. PILLERSDORF: They are only for I.D., one of
9 ones that are only for I.D.
10 THE COURT: I said you may.
11 MR. PILLERSDORF: Oh, okay.
12 THE COURT: We can use the blackboard.
13 MR. PILLERSDORF: I don't write well on it. Thank
14 you.
15 Q We know that her IV began at about 2 or 2:06?
16 MR. HELLER: Your Honor, you know, if Mr.
17 Pillersdorf is going to testify we don't need the doctor.
18 I object to the form of the question.
19 THE COURT: Overruled. Let's move it.
20 MR. PILLERSDORF: Thank you.
21 Q Again doctor, assume that all these are times -- you
22 have reviewed the record, if you see anything that's wrong, but
23 these are times that we established yesterday that anesthesia
24 began at 2:30?
25 MR. HELLER: Your Honor, I am objecting.
0372
1 THE COURT: Overruled.
2 Q The tourniquet was put on at 3:05 and that the first
3 incision --
4 MR. HELLER: Your Honor, again the testimony
5 wasn't that the tourniquet was put on at 3:05, it was that
6 it was inflated, I think.
7 THE COURT: What is that sheet that you have in
8 your hand, counsel?
9 MR. PILLERSDORF: My notes from yesterday, they
10 are my notes taken from the hospital record and the
11 testimony which I had transcribed. I am trying to save
12 time as the Court instructed.
13 THE COURT: Okay. Proceed.
14 MR. PILLERSDORF: Thank you.
15 THE COURT: Proceed.
16 Q We know that the tourniquet was released at 4:17,
17 pardon my handwriting.
18 The chart uses the word surgery complete at 4:25;
19 she's off the table at 4:30; and at 4:40 she's in PACU, her
20 vitals are being taken; at 5:30 she's out of bed; at 5:35
21 she's in PACU-2, the other room; and then she's discharged.
22 Now, I want to ask you doctor, between 3:08 and some
23 time before 4:17, the surgery has been completed; is that
24 correct?
25 MR. HELLER: Objection.
0373
1 A Yes.
2 THE COURT: Grounds?
3 MR. HELLER: Form, your Honor. Evidence that's
4 not quite correct.
5 THE COURT: You do know based upon your experience
6 where there's an objection you are to offer no additional

7 testimony until I rule.
8 THE WITNESS: I know.
9 THE COURT: Objection sustained.
10 Q How long should this procedure take, normally?
11 A It can take 30 minutes to an hour and-a-half, depending
12 on the findings that you see during the case.
13 Q The fact tourniquet on at 3:05, tourniquet off 4:17, is
14 that appropriate, the standard?
15 A It's reasonable.
16 Q That's all we want.
17 MR. HELLER: Your Honor, "that's all we want", I
18 mean, what are we doing here commenting on the answers?
19 MR. PILLERSDORF: Come on.
20 MR. HELLER: From expert witnesses, it's
21 ridiculous.
22 THE COURT: Limit the commentary, please.
23 MR. PILLERSDORF: Okay.
24 Q With regard to appropriate surgical procedure, after
25 the surgery is completed what are the steps, you finish the

1 surgery, describe the closing procedure, what are the general
2 steps?
3 A Well, obviously when you perform the surgery you have
4 to cut open the skin and you perform the surgery; then you have
5 to suture or close the skin, everybody knows what stitches are;
6 and then you apply gauze or sterile gauze bandage which is to
7 keep the area from getting infected and to absorb any possible
8 bleeding.
9 Q Let me stop you there.
10 Doctor, the closure, closing the stitches, would that
11 be done with the tourniquet on or off?
12 A That's the doctor's choice. You can do the stitches
13 before you let the tourniquet go. Sometimes in certain
14 procedures if you're anxious about we call hemostasis you let
15 the tourniquet down before you close the skin to see if there
16 are any bleeders you need to fix before you close the skin.
17 Q The initial layers of gauze or the dressing to the
18 ankle itself, the surgical site, would that be done before or
19 after the tourniquet is released?
20 A That just depends on the individual doctor, it depends
21 on where you are in the process. As long as you keep everything
22 sterile you can get the tourniquet released before you put the
23 bandages on, or after, either is appropriate.
24 Q Once the surgery is complete, once you have done your
25 repair, closed the operative field, closed the skin and dressed

1 the particular wound, what has to be done to the leg itself in a
2 peroneal tendon repair such as this?
3 MR. HELLER: If anything?
4 Q If anything?
5 A Well, because the tendons need stabilization we will
6 apply some -- typically we will apply what's called a posterior
7 splint, which is the back part -- posterior back, anterior is
8 front -- the back part of the cast to stabilize the foot in a

9 position so we don't put any strain on those surgically repaired
10 tendons. All we did to repair the tendons is stitches, it's
11 like thread from a needle, so obviously if the leg is allowed to
12 move it can disrupt what we did fix.
13 Q Stabilization to prevent -- to allow the wound to heal,
14 how long in this type of surgery is it appropriate to stabilize
15 the ankle joint?
16 A Well, repair of the tendons, tendons typically heal
17 relatively quickly compared to bone, so depending on how much
18 damage there is four to six weeks of stabilization, either with
19 a splint or a cast.
20 Q We've heard talk about -- we've heard cast, we've heard
21 splints, they all use the word 90 degrees, what does that refer
22 to?
23 A That's the position of the foot on the leg, because
24 that helps to put everything in alignment; it also helps to keep
25 the ankle from getting stiff afterwards and stabilizes the foot

0376

1 in position so it will heal the best.
2 Q And to do the stabilization what are the methods
3 available -- withdrawn.
4 What is, in your opinion, the appropriate method to
5 stabilize the leg post -- immediately postoperatively in a
6 tendon repair?
7 A Well, as you know, as I mentioned, my medical school
8 training and then residency training and then private practice
9 what we were taught and what we do is to stabilize the foot in a
10 splint first to allow for any swelling that might occur after
11 surgery.
12 MR. HELLER: I move to strike. I don't know if
13 this is standard of care or just what he likes to do.
14 THE COURT: Granted. Read back the question or
15 rephrase it.
16 MR. PILLERSDORF: I will rephrase the question.
17 Q Doctor, in New York our requirement is that -- I am
18 going to be asking you questions of what the standard of care in
19 your opinion whether it was met or departed from.
20 First of all, can you tell the jury, so we are on the
21 same page, what standard of care in your mind means?
22 A Standard of care in my mind is what a skilled
23 physician, what is considered appropriate treatment by a skilled
24 physician -- excuse me, by I would say an average skilled
25 physician in similar circumstances like this case.

0377

1 Q When you say average skilled physician, this doesn't
2 have to be the worse guy or the best guy, it's what an
3 average -- what do you mean by average?
4 MR. HELLER: Objection, your Honor.
5 MR. PILLERSDORF: Withdrawn.
6 Q Could you exemplify or tell us more about when you say
7 "the average physician" what that refers to?
8 MR. HELLER: May I -- objection, your Honor.
9 THE COURT: Sustained.
10 Q Doctor, in your opinion using standard of care what the

11   average physician appropriately trained for this would do --
12   we're talking about podiatrists here, correct?
13   A   Yes.
14   Q   -- what the average podiatrist would do in this
15   situation, do you have an opinion as to the appropriate way of
16   immobilizing the leg following the surgery as described in the
17   hospital record, that surgery?
18   A   The appropriate way is to apply the posterior splint,
19   which is the back part of the cast, which will stabilize the
20   surgical procedure, prevent injury from where you just did the
21   surgery, and allow for swelling.
22   Q   Doctor, the difference between a splint and a cast,
23   could you tell us what do you mean by that, can you describe the
24   differences?
25   A   I think most of us have seen a person with a cast on

1   their leg, and you can see how it goes all the way around. Now,
2   the toes are exposed and it will go from the front of the foot
3   all the way up the leg like a tube, maybe even some of you had
4   had a cast on before, that means it goes all the way around from
5   below the knee to the foot like a tube. A splint is just the
6   back part of a cast, there's gauze padding, and use an Ace
7   bandage to keep it in place.
8   Q   When a splint is created does the splint protect or
9   does the splint support the plantar or the bottom of the foot?
10   A   Yes.
11   Q   These 90 degree splints that you're talking about, do
12   they protect the lateral and medial side of the foot, in other
13   words, when you do a 90 degree splint are the sides protected?
14   A   Yeah, the whole foot is protected. I mean it's
15   stabilized, obviously with not having a cast on the top of the
16   foot you can argue that that's relatively unprotected, but it
17   stabilizes the whole foot and ankle.
18   Q   On the back of the foot -- may he come down again, your
19   Honor?
20   THE COURT: Yes.
21   Q   Can you show the jury when you're talking about a
22   splint what area would be covered by the hard material of the
23   splint?
24   A   Well, it's similar, I can use this as a model.
25   Just picture this with the plastic part going all the

1   way up, that would be the splint. And the front --
2   THE COURT: The witness is demonstrating utilizing
3   a boot that is referred to as a --
4   MR. PILLERSDORF: EMI walk -- EBI cam walker.
5   MR. HELLER: Could you just do it again, doctor?
6   Thank you.
7   A   EBI is the company that makes it. Cam walker or
8   fracture boot, all different terms for it but it's all the same
9   thing and this is the way to stabilize the foot for treatment.
10   I was just using this as an example because I don't have a
11   Fiberglass cast to show you. If you enclose this and make
12   believe that's fiberglass, that is your splint.

13 Q How about the side pointing to the medial and lateral
14 aspect, this seems to go under the foot, would the splint give
15 any lateral traction or lateral support?
16 A It gives relative support, it doesn't give a lot of
17 protection because it's kind of open, but it does support the
18 foot and stabilize it.
19 Q What I am asking is, does it cradle the foot or is the
20 foot sitting on top of it?
21 A It depends on how you put it on, but usually the foot
22 is sitting on top of it, you don't want any pressure on the
23 sides to cause any injury.
24 Q Is that something -- first of all, is it made -- you
25 can resume the witness stand.
0380
1 (Whereupon, the witness resumed the witness stand.)
2 Q Is that constructed in the operating room?
3 A Yes, we get Fiberglass material, it comes in sheets,
4 you wet it so it activates it, so it will be moldable and put
5 Ace wrap around it and it hardens and becomes a hard cast.
6 THE COURT: We're going into luncheon recess at
7 this point.
8 Members of the jury, we'll resume promptly at two
9 o'clock. Be back. See you then. Enjoy your lunch.
10 (Whereupon, the jury left the courtroom.)
11 (Whereupon, luncheon recess was taken.)
12 A F T E R N O O N S E S S I O N.
13 (Whereupon, the jury entered the courtroom.)
14 THE CLERK: Both sides stipulate the jury is
15 present and properly seated?
16 MR. PILLERSDORF: Yes.
17 THE COURT: Good afternoon.
18 Proceed.
19 Q We were talking about the procedure and the
20 stabilization, that's what we're focusing in on now. If a
21 tendon repair is not stabilized what are the risks?
22 A The risks are that you will compromise the results of
23 the surgery. As I stated it's sewn together with suture
24 material or stitching and if it's not stable the stitching can
25 come apart and the results of the surgery can fail.
0381
1 Q The 90 degree cast, the 90 degree splint that we talked
2 about, in your experience is that something that can be placed
3 on the patient in the operating room?
4 A Yes.
5 Q Is it generally done before the patient is awake, while
6 the patient is still in a twilight zone, when is it done?
7 A It can be done any time, typically, to make it easier.
8 Typically when a patient is under general anesthesia sometimes
9 when they are waking up they move around a lot, we can put the
10 splint on before anesthesia is completely released.
11 Q Doctor, returning to this case, in the operative
12 report -- do you have that?
13 MR. PILLERSDORF: Your Honor, may the doctor use
14 his own copy?

15 THE COURT: Yes.
16 Q Doctor, in the operative report, actually the last line
17 of the operative report, what is the comment the surgeon makes?
18 A The last sentence in the operative report by Dr.
19 Lombardi dated 8/23/05 states: The patient was placed into a
20 short leg cast.
21 (The following is transcribed by Mary Benci.)
22 (Continued on next page.)
23 * * * *
24
25
0382
1 DIRECT EXAMINATION (Continued)
2 BY MR. PILLERSDORF:
3 Q Now, we see in the chart, we see in the record,
4 medically speaking, all right, is there a distinction between
5 a short leg cast and a 90-degree splint?
6 A Well, as I testified earlier, the splint is the
7 back part of the cast, whereas a short leg cast means that
8 the material, the fiberglass is applied all the way around
9 like a tube from below the knee, pardon me, to in front of
10 the toes.
11 Q All right. Now, in the nurse's note, all right, in
12 the hospital chart, referring actually to the postoperative
13 nurse's notes, do they refer to any immobilization?
14 A Actually, included in both the intraoperative phase
15 which is the --
16 Q Let's go slower. Intraoperative means what?
17 A While you are in the operating room.
18 Q What does it say there?
19 A The RN, I can't read her name, specifically, it's a
20 long name, but it states comments: Cast applied to left
21 lower leg.
22 Q In the PACU notes, what are they saying?
23 A PACU is the after surgery area, recovery area. And
24 I'm not sure if it's Nurse Emery, but there is a nurse's
25 signature here, and under nurse's notes from the PACU, it
0383
1 states: Left lower leg cast in place.
2 Q All right. Is there another reference to the cast
3 on the -- I think it's the second column of that?
4 A Yes. On the -- I can't read it specifically.
5 You'd have to get the nurse's exact interpretation, but it
6 does refer to left foot cast, I guess, again, it says in
7 something, toes warm.
8 Q Okay. Is the word in situ?
9 A I think that's what it means.
10 Q If that was what the term was, perhaps that's what
11 the nurse put here, what does in situ mean?
12 A It's a doctor word meaning in the body, like the
13 body.
14 Q So in at least in those documented records it
15 indicates that a cast was placed?
16 A Correct.

17 Q Doctor, I'm going to ask you a hypothetical
18 question now. Assume, if you will, that we have a
19 63-year-old patient, assume that she's been active, she has a
20 history consistent with a history that you're familiar with
21 in this patient. Assume that she has anywhere from a year to
22 a month of chronic pain along with peroneal tendon. Assume,
23 if you will, that the doctor determines after MRI that he
24 believes that surgical intervention is needed to repair a
25 torn tendon, that he believes that there's a dislocation.

0384

1 Assume that the patient is anesthetized, all right, and then
2 operated on as we've seen in the operative chart.
3 Do you have an opinion within a reasonable degree
4 of podiatric certainty as to whether or not the placement of
5 a short leg cast immediately postoperatively, actually in the
6 operating theatre, all right, is consistent or a departure
7 with good and appropriate standards in the podiatric
8 community? Do you have such an opinion?
9 A Taking all those things into consideration,
10 application of a cast and not cutting the cast to relieve for
11 pressure is --
12 MR. HELLER: Objection, your Honor. That wasn't
13 the hypothetical.
14 Q I'll do it phase by phase. Everything that we've
15 read said a cast was placed. There's a cast in site.
16 There's a cast, all right. The last line of the operating
17 room is a short leg cast. Would placing a cast immediately
18 postoperatively on a patient who's had peroneal tendon
19 repair, dislocation repair, do you have an opinion as to
20 whether that would be a departure from accepted podiatric
21 standards?
22 A With reasonable medical certainty that is an
23 absolute departure from the standard of care in this case.
24 Q Okay. Now, before we go any further, could you
25 tell us, Doctor, what risks there are in this departure; in

0385

1 other words, if one has put a cast on, what are the intendant
2 risks and why is it not done?
3 MR. HELLER: Objection to the form of the question.
4 THE COURT: Sustained.
5 Q Could you tell us why you believe it's a departure
6 to put a short leg cast on a postoperative peroneal patient
7 such as this?
8 A With any surgical procedure we're all familiar with
9 the idea that swelling can occur. That's increased fluids at
10 the area because of healing; that is a normal reaction. When
11 you have swelling in a cast, an applied cast can't give.
12 It's like a vice; there's no movement. It's like having your
13 belt on too tight. So with more fluid and swelling, it can
14 hurt the tissues starting from the skin and cause skin
15 damage, and then the underlying soft tissues, like nerves,
16 arteries, veins, muscles, tendons, they can get strangled
17 from the pressure. We've all felt it when we crossed our leg
18 how your leg will hurt; that's from the pressure on the nerve

19   alone. We can't control the swelling in a cast.
20   Q   Okay. Doctor, if a cast is put on, assume further,
21   if you will, that three to four weeks after immobilization,
22   all right, the patient who has been complaining and has given
23   indications of swelling at various postoperative visits, but
24   the first time she tries to ambulate, all right, assume that
25   the patient is observed and determined medically to have a
0386
 1   drop foot. All right, do you have an opinion within a
 2   reasonable degree of medical certainty as to whether or not
 3   the application of a cast would be a proximate cause or a
 4   direct causative factor in causing the drop foot?
 5   A   With a reasonable degree of medical certainty, I
 6   agree that it's a proximate cause that the cast caused nerve
 7   damage and resulted in the drop foot problem.
 8   Q   All right. And the mechanism by which that
 9   happens?
10   A   There's nowhere for the swelling to occur. The
11   surgery was below the ankle -- or in the ankle and foot area,
12   but with the cast on the swelling will even progress up the
13   leg, and without any allowance for the swelling to occur now
14   the cast becomes a vice and causes pressure within the soft
15   tissues. We sometimes call that a compartment syndrome, but
16   it's damage and pressure, and the tissues will get damaged
17   and in this case the nerve damage occurred.
18   Q   And the results of -- which nerve are we talking
19   about will be damaged?
20   A   In this case the common peroneal nerve.
21   Q   That's the one you indicated runs fairly
22   superficially or close to the surface as it gets up towards
23   the knee?
24   A   Correct. As I showed you earlier in the diagram,
25   that's the one that's in yellow that comes in right below the
0387
 1   knee and wraps around the fibula or the outside ankle bone.
 2   It's very exposed.
 3   Q   When this nerve damage takes place, the drop foot
 4   that develops from it or which can develop from it how is
 5   that diagnosed? What manifestation does the drop foot show?
 6   A   Drop foot is a result of muscle weakness because
 7   the nerve is not telling the muscle what to do correctly.
 8   The first indication is a physical exam to test somebody's
 9   range of motion or how much they can resist when you push or
10   pull against their feet. Doctors probably have done that to
11   have you test your strength. The true diagnosis for a drop
12   foot is to have somebody walk. And you can have different
13   levels of weakness where you can examine a patient and they
14   don't seem to have much weakness, but when they walk it's
15   obvious.
16   What a drop foot is, is the foot won't clear on the
17   ground, and as you go forward it will slap against the
18   ground. And also for you to be able to move forward and have
19   your -- in this case your left foot clear the ground, your
20   right foot has to make up for it and you go up on your toes.

21   They call it a steppage gait. It looks like you're trying to
22   step over a curb because you have to raise up your left leg
23   high enough so your toes don't hit the ground.
24   Q   Now, what we've seen from the records, all right,
25   of Dr. Lombardi, that he first observed the drop foot on the
0388
1   28th, and it says when she was first walking. In your review
2   of the records -- withdrawn. Let me do this.
3   You had the opportunity to look at the Maspeth
4   records; is that right, Doctor?
5   A   Yes.
6   Q   And this therapy was initiated when she was given
7   the boot-like cast; is that correct?
8   A   Yes.
9   Q   Okay. Now, on the second visit you indicated
10   there's a notation on the 9/21 that there's clear notation of
11   the drop foot; however, if you could review the record from
12   the 19th, could you tell me what the findings were.
13   THE COURT: What record are you referring to?
14   MR. PILLERSDORF: The Maspeth record. It's number
15   11, I believe.
16   MR. HELLER: Objection to the form, your Honor.
17   COURT OFFICER: Number 9.
18   MR. PILLERSDORF: Number 9. I'm sorry. Thank you.
19   A   In front of me I have the Maspeth Physical Therapy
20   records dated September 19th, 2005, which are of
21   Jeanette Licitra and it diagnoses status post left peroneal
22   tendon repair. And in the gait evaluation they watched her
23   walk with the -- with crutches and the boot, the left foot
24   cast, they called it, in place. And under problem they have
25   decreased range of motion, decreased strength, and it says
0389
1   ADL. I think that means decreased ankle dorsiflexion, is how
2   I interpret it. You would have to ask the physical therapist
3   to confirm that.
4   Q   So on the records from the 19th is there any
5   indication of peroneal nerve compromise in the patient from
6   that therapy record?
7   A   There is.
8   MR. HELLER: Objection, your Honor.
9   THE COURT: Sustained.
10   Q   Doctor, is that record, in your opinion, consistent
11   with the injury that we've -- that has been diagnosed in this
12   patient?
13   A   I will say that they didn't have the opportunity to
14   evaluate her --
15   MR. HELLER: Objection, your Honor. He doesn't
16   know what they had time to do.
17   THE COURT: Sustained.
18   Q   The examination that they did of her, how was she
19   walking? Is that indicated in the record?
20   A   She was ambulating with crutches and a left foot
21   boot cast.
22   Q   All right. The drop foot gait, would that be -- is

23   that apparent, all right, when someone ambulates with we know
24   it to be that walker thing, the EBI Cam Walker and crutches?
25   In other words, would you see it when you're walking in that?
0390
1   A   No.
2   MR. HELLER: Objection, your Honor.
3   THE COURT: What happens when there's an objection?
4   THE WITNESS: I'm answering too quickly, ma'am.
5   THE COURT: You did. Overruled. Don't let it
6   happen again.
7   Q   Can it be observed when they're walking like that?
8   THE COURT: He answered that already. There was an
9   objection to it. He answered it. Moving on.
10   MR. PILLERSDORF: But his answer is in? I mean,
11   the objection is -- wasn't sustained?
12   THE COURT: The answer is in. You don't need to
13   ask the question again.
14   MR. PILLERSDORF: Okay.
15   Q   Doctor, in reviewing the record on 9/28/05, this is
16   Dr. Lombardi's record, all right, and the word that he uses:
17   Upon attempted gait, she has what appears to be a drop foot
18   weakness, is that correct, drop foot and weakness?
19   A   Yes.
20   Q   All right. And that's the first note you got from
21   Dr. Lombardi that he has indicated that he found it; is that
22   correct?
23   A   Yes.
24   Q   And that's the first time he saw her attempt to
25   ambulate?
0391
1   A   According to the records, yes.
2   Q   In his record on a note made after he was aware
3   that the patient had contacted a lawyer, all right, he
4   comments, and I'll read the note:
5   MR. HELLER: Objection to the preamble, your Honor.
6   THE COURT: Sustained.
7   Start again, Counsel, without the commentary.
8   Q   The record reads: Furthermore, she was seen by
9   physical therapy on September 19th, which preceded my visit
10   and the diagnosis of palsy and, apparently, according to the
11   physical therapist there was no evidence of the palsy at the
12   time.
13   Based upon your review of the record from that
14   particular date, I won't even refer to the 21st, but based
15   upon your review of the record of the 19th, do you agree with
16   that statement that the doctor put in his chart?
17   A   No.
18   Q   All right. Do you find evidence then of -- when
19   they say palsy they're talking about the drop foot; is that
20   right?
21   A   Palsy is weakness.
22   Q   Okay. And in fact, in the actual record of
23   September 19th, is there indication of weakness?
24   A   There is.

25 Q Okay. Now, Doctor, let's move on from the cast.
0392
1 The risk of a full cast you've told us is
2 compression. Are there ways to alleviate that risk?
3 MR. HELLER: Objection to the form of the question.
4 THE COURT: Overruled.
5 You may answer.
6 A Yes.
7 Q Could you explain how you would alleviate, if you
8 put on a low leg cast, how can you alleviate the risk of
9 compression?
10 A It's called bivalve or cutting two places on both
11 sides of the cast from the knee down and that relaxes the
12 cast and it gives you some room for swelling. It's not
13 perfect, but it's a help.
14 Q Okay. Doctor, would the failure -- if the plan is
15 to bivalve a cast, would the failure to bivalve it be a
16 departure of accepted standards in the podiatric community
17 within a reasonable degree of certainty on your part? Do you
18 have such an opinion?
19 A Yes.
20 Q And what would that opinion be?
21 A That it is a breach of the standard of care to a
22 reasonable degree of medical certainty because of the
23 injuries that can occur, as I explained, without splitting or
24 bivalving the cast.
25 Q Now, hypothetically, let us assume that we have the
0393
1 surgery as indicated in the chart, that in the surgical and
2 the operative report it says that a cast was placed. In the
3 PACU it says that the cast was intact. All right. It says
4 in various places that the cast was in situ, all right.
5 Assume, if you will, that the patient testifies
6 that her recollection is when she came back two days
7 afterwards to see the doctor, a young man in his office,
8 presumably part of his staff, before the doctor came in to
9 examine her used an implement that we've demonstrated or
10 shown to the jury, a cast cutter, all right, and with a lot
11 of noise and a lot of on and off, all right, proceeded to cut
12 the -- whatever immobilization she was in, proceeded to cut
13 that off. All right.
14 Based upon that factor, would you have an opinion
15 within a reasonable degree of medical certainty whether there
16 had been a violation in the standard of care in the treatment
17 of this patient from a podiatric point of view?
18 MR. HELLER: Objection.
19 THE COURT: Sustained.
20 Q Doctor, if a patient needed to have her cast cut
21 off with a cast cutter -- withdrawn.
22 Would a 90-degree splint, all right -- withdrawn.
23 Would a bivalve cast -- if the cast had been
24 bivalved at any time in the hospital, would it be necessary
25 in your opinion for it to be removed with a cast cutter two
0394

 1   days following, at the first postoperative visit, assuming
 2   she has done nothing to the cast?
 3   A   Absolutely not.
 4   Q   The cutting with the cast saw and the spreader,
 5   that's a one-shot operation; it's only done to remove full
 6   casts?
 7   MR. HELLER: Leading.
 8   THE COURT: Rephrase, Counsel.
 9   Q   All right. Doctor, is there ever a need to use a
10   cast cutter -- withdrawn.
11   In the 90-degree splint cast that you talked about,
12   would that have to be removed -- if done properly, would that
13   have to be removed with a cast cutter?
14   A   No.
15   Q   Now, Doctor, from the record and from the timeline,
16   all right, do you have an opinion as to whether, assuming
17   that the incision was made at 3:08, the tourniquet was
18   removed at 4:17, the nursing staff marked the case complete
19   at 4:25, and the patient was taken off the table at 4:30,
20   within that time frame, before she gets to PACU, the first
21   phase, in your opinion could a cast, all right, of fiberglass
22   be appropriately applied and bivalved in that time sequence?
23   MR. HELLER: Objection, your Honor.
24   THE COURT: Grounds?
25   MR. HELLER: This is wizardry. We're taking --
0395
 1   THE COURT: No, no, no. Say no more.
 2   MR. HELLER: Form, your Honor.
 3   THE COURT: Sustained.
 4   MR. PILLERSDORF: As to form?
 5   THE COURT: Yes.
 6   Q   Doctor, the cast, in your opinion, the beginning of
 7   the -- not wrapping for dressing, but the cast, all right,
 8   would that be put on after a tourniquet is released in
 9   accordance with good practice?
10   MR. HELLER: Objection. That's a leading question.
11   THE COURT: What?
12   MR. HELLER: I said objection. It's a leading
13   question.
14   THE COURT: You may answer.
15   A   It is appropriate to release the tourniquet to let
16   the area revascularize before you put the cast on, so that's
17   correct.
18   Q   Doctor, how long does the revascularization process
19   take if the tourniquet is released, if you can answer it?
20   MR. HELLER: Objection, your Honor. There's no
21   basis for this, I don't think.
22   THE COURT: Overruled.
23   You may answer it.
24   A   When a cast is applied, in this case for
25   approximately one hour, the rewarming or what we call
0396
 1   hyperemia, there's an increased blood flow afterwards.
 2   THE COURT: Just a moment. Read back the question,

3 please.
4 MR. PILLERSDORF: I'll reask it.
5 Q If a tourniquet is released at 4:17 after a
6 one-hour surgery, all right, is there a period of time for
7 the revascularization before it's appropriate to begin to put
8 a cast on?
9 A I don't have that exact answer.
10 THE COURT: So you don't know. Next question.
11 Q Can you give an approximation?
12 MR. HELLER: Objection.
13 Q What is the process that has to take place before
14 you can put the cast on after you release the tourniquet?
15 A We want to check the vascular status to the toes.
16 We want to see that the circulation has returned to what we
17 consider a normal state, and that can be different in
18 different patients. It could be immediate and sometimes it
19 can take 20 or 30 minutes.
20 Q All right. We've had yesterday testimony that --
21 withdrawn.
22 If Dr. Lombardi stated in his deposition that it
23 takes ten minutes for the plaster to dry or then he said from
24 five to ten, but at one point we read ten, and one point he
25 said five to ten, is that consistent with your experience for
0397
1 the fiberglass casts?
2 A Yes.
3 Q All right. Can you cut them while they're wet? Or
4 I shouldn't say can. Is it appropriate to cut them while
5 they're still drying?
6 THE COURT: Them being?
7 MR. PILLERSDORF: Them being the cast. I'm sorry,
8 your Honor.
9 A No, it's too difficult. The saw will get caught up
10 in the wet fiberglass.
11 Q Doctor, from this record, from the totality of the
12 surgical timeline, from the notes with regard to the
13 notations in the PACU about the cast intact, with the notes
14 from the surgical note that a short leg cast was put on --
15 withdrawn.
16 Is there any indication -- I'm going to ask you to
17 disregard the surgeon's last note that says the resident to
18 split -- resident split cast, is there any indication from
19 any of the nurse's notes, any indication from any of the
20 nurse's notes that the cast was bivalved?
21 A None.
22 Q Doctor, the word bivalve cast is an accepted term;
23 physicians are aware of it?
24 A Physicians are, yes.
25 Q Hospital staffs, they understand a bivalve cast and
0398
1 a short leg cast are two different things?
2 A Yes.
3 Q A 90-degree split cast is a third thing?
4 MR. HELLER: Objection.

5 THE COURT: Sustained as to form.
6 Q Doctor, do each of those terms, cast, short leg --
7 cast, short leg cast, bivalve cast, 90-degree splint, are
8 those terms independent and have their own meaning?
9 A Yes.
10 Q Doctor, am I correct that if a physician decided to
11 put a short leg cast and bivalve it, all right, as opposed to
12 doing a splint, a 90-degree splint, all right, the result
13 would be the same if in fact it was bivalved?
14 A Yes.
15 Q Are there risks in doing a cast and bivalving it as
16 opposed to just putting in the 90-degree splint?
17 A Yes.
18 Q Could you tell us what those are.
19 A Well, I think the inherent risk is, like in this
20 case, that the bivalve wasn't completed or done. What
21 happens with the bivalve, you have to do a very good job to
22 release all of the cast material from top to bottom, and
23 sometimes the materials underneath, because even if with the
24 cast applied the underneath cotton padding can be tight too.
25 Q But assuming we're going to use the method of using
0399
1 a bivalve, all right, and you've already told us it would be
2 a departure not do it; is that correct?
3 A Not to bivalve the cast in an immediate
4 postoperative immobilization, correct.
5 Q Doctor, from your review of this record, the
6 surgical report, the nurse's note, all right, do you have an
7 opinion -- and the postoperative course of the patient, do
8 you have an opinion within a reasonable degree of podiatric
9 certainty as to whether or not this patient had a bivalve
10 cast?
11 MR. HELLER: Objection, your Honor. That's the
12 ultimate question for the jury.
13 THE COURT: Overruled.
14 MR. PILLERSDORF: You may answer.
15 A Understanding all of the facts that I was -- I
16 reviewed, that's true, the bivalve did not occur.
17 Q Doctor, do you have an opinion within a reasonable
18 degree of medical certainty, is the failure to do the
19 bivalve, all right, the cause of the drop foot that this
20 patient has demonstrated both in Dr. Lombardi's note, the
21 therapy notes and the other notes you've seen?
22 MR. HELLER: Objection.
23 THE COURT: Overruled.
24 A Yes.
25 Q All right. Doctor, continuing on.
0400
1 MR. PILLERSDORF: And your Honor if I may, just
2 subject to connection for the doctor.
3 THE COURT: How much more continuing on?
4 MR. PILLERSDORF: Two or three more questions. I'm
5 just getting to the RSD part, that's all.
6 Q Doctor, did you become aware that the patient's

7 condition or the patient developed a complex -- complex
8 reflex pain syndrome or an RSD, or whatever they're calling
9 it now; are you aware of that?
10 MR. HELLER: Objection, your Honor.
11 THE COURT: Grounds?
12 MR. HELLER: 3101D.
13 MR. PILLERSDORF: May we approach, your Honor?
14 THE COURT: Yes, please.
15 (Whereupon, an off-the-record conference was held
16 between all counsel and the Court at the side-bar.)
17 THE COURT: Objection sustained.
18 Q Doctor, with regard to drop foot, all right, the
19 etiology of the cause of the drop foot is nerve damage; is
20 that correct?
21 A In this case, correct.
22 Q All right. Can nerve damage respond in various
23 ways over time?
24 A Yes.
25 Q Okay. Again, you've never followed this particular
0401
1 patient, all right, but with regard to nerve damage, all
2 right, it can completely resolve; is that correct?
3 A In rare instances, yes.
4 Q Okay. It can remain constant; is that correct?
5 A Yes.
6 Q It can develop additional complications. We're not
7 going to go into what they are. Well, actually, I will do
8 the cause relation.
9 It can resolve into something called RSD or --
10 MR. HELLER: Objection, your Honor.
11 THE COURT: Sustained.
12 Q Leave it for the neurologist.
13 With regard to the physical manifestation of the
14 drop foot, all right, would you tell us -- well, with regard
15 to your experience, when a patient has a drop foot caused by
16 a -- caused by nerve damage to the peroneal nerve, all right,
17 will that resolve?
18 A It depends on the reason for the injuries. There
19 are certain cases, for example, with diabetes and
20 neuromuscular disorders where the nerves won't recover.
21 Q Okay. In a situation where it's caused by
22 compression, all right, all right, can that -- withdrawn.
23 Doctor, do you have an opinion within a reasonable
24 degree of medical certainty, does that create a permanent
25 condition, the drop foot?
0402
1 MR. HELLER: Objection.
2 THE COURT: Rephrase.
3 Q Doctor, obviously, the patient doesn't have MS and
4 doesn't have some of the other things we talked about or that
5 you just mentioned. Where the peroneal nerve damage is
6 caused by compression of the nerve from a cast that was
7 placed and not bivalved, can you tell us the progression or
8 what will happen with that nerve? Can it cause permanent

9 nerve injury?
10 MR. HELLER: Objection.
11 THE COURT: You may answer.
12 A Yes.
13 Q Okay.
14 THE COURT: One more question?
15 MR. PILLERSDORF: If it's one, I've got to think
16 about it, you know. You thought I was going say okay,
17 but I'm not about to say okay. I was good today with
18 okay. You didn't notice that.
19 THE COURT: Speak while you think. Time is
20 fleeting.
21 Q Doctor, is a drop foot a competent producing cause
22 of pain and discomfort in a patient?
23 A Can be.
24 Q Is drop foot a competent producing cause of
25 interference with gait and mobility?
0403
1 A Every time.
2 Q Is drop foot something that can impede on someone's
3 ability to play tennis, sports, other factors?
4 A Absolutely.
5 Q With regard to the pain --
6 THE COURT: We're up to number four. I gave you
7 one.
8 MR. PILLERSDORF: It's multiple choice, Doctor --
9 Judge.
10 Q Doctor, in your opinion based on your review of the
11 facts, all right, did this patient develop a drop foot
12 because of a failure to either properly cast or failure to
13 bivalve the cast?
14 THE COURT: Asked and answered.
15 MR. HELLER: Asked and answered.
16 MR. PILLERSDORF: You don't have to do his job,
17 okay. Thank you, Judge.
18 THE COURT: I do all of the jobs.
19 MR. PILLERSDORF: I've become aware of that. No
20 further questions, your Honor.
21 THE COURT: Cross-examination.
22 CROSS-EXAMINATION
23 BY MR. HELLER:
24 Q Hello, Doctor.
25 A Hello, Mr. Heller.
0404
1 Q We've never met?
2 A I think we have.
3 Q We have? Where and when might that have been?
4 A I'm not sure if I met you in Fairfax or a Region 8
5 meeting.
6 Q Who, Region?
7 A Eight in Maryland. I might be wrong. We were on a
8 panel for -- I might have you mistaken, but it was a number
9 of years ago. It was a pica --
10 Q Was I bright and witty?

11 A You were fabulous.
12 Q All right.
13 MR. PILLERSDORF: That was me.
14 Q We must have met, all right.
15 Doctor, I represent Dr. Lombardi. Do you know him?
16 A I only know him from the records.
17 Q Do you know of him?
18 A Only from the records provided to me.
19 Q All right. I heard you say that you were Board
20 certified by the American Board of Podiatric Surgery, right?
21 A Correct.
22 Q And that's the chief podiatric surgical
23 certification in the United States, right?
24 A I agree.
25 Q Right. And Dr. Lombardi was the president of that

1 organization a few years ago, right?
2 A I understand that, correct.
3 Q So that would suggest that he's also --
4 MR. HELLER: Objection.
5 Q -- Board-certified by the American Board of
6 Podiatric Surgery, right?
7 A I would think he would have to be, right.
8 Q Okay. Doctor, you've testified before in courts?
9 A On several occasions, yes.
10 Q All right. You've testified in many states in this
11 country?
12 A No.
13 Q You've given deposition testimony in many states in
14 this country?
15 A I've given deposition testimony that involved cases
16 in many states.
17 Q How many states?
18 A I don't have an exact number. I wouldn't doubt if
19 it's twenty.
20 Q Twenty states?
21 A Maybe.
22 Q AB?
23 A Maybe.
24 Q Maybe, maybe, okay.
25 A I don't have a list.

1 Q All right. And I assume that you're paid for doing
2 these things?
3 A I'm reimbursed for my time out of the office,
4 correct.
5 Q Did Mr. Pillersdorf tell you he would reimburse you
6 for your time out of the office on this case?
7 A Yes.
8 Q Did he tell you it would be in American money?
9 A I didn't get that answer.
10 MR. PILLERSDORF: Why did you tell him that?
11 A Could I ask?
12 MR. HELLER: I'm giving away his secret.

13 MR. PILLERSDORF: And don't ask if the check clears
14 either.
15 Q When did you meet Jeanette Licitra for the first
16 time?
17 A This morning.
18 Q In court?
19 A Outside of the courtroom.
20 Q You never examined her?
21 A No.
22 Q Prior to today?
23 A No.
24 Q She was not your patient?
25 A No.

0407

1 Q And you were retained by Mr. Pillersdorf's
2 predecessor's firm, is that right, Shafran and something or
3 other?
4 A Mosley, Shafran & Mosley.
5 Q Shafran & Mosley?
6 A Correct.
7 Q And they got your name from a service, was it?
8 A It's a nurse -- there are nurses that provide an
9 intermediary between lawyers for search of medical experts
10 and the medical experts.
11 Q I see.
12 And, you know, in a typical year, you could take
13 any year you like, 2004, five, six, how many cases,
14 malpractice cases would you commonly get involved in? And by
15 that I mean a nice young man like Mr. Pillersdorf sends you
16 records to review, and you review the records, and you make a
17 phone call and you talk to the lawyer, you send a bill?
18 A Well, I don't keep any ongoing lists. Depending on
19 the year, I would estimate anywhere between ten to twelve
20 cases. Sometimes in the last ten years I might have only had
21 five or six, and most recently, I don't know why, I've gotten
22 quite a few.
23 Q You've gotten quite a few; is that what you said?
24 A Correct.
25 Q All right. Did you ever testify that you review

0408

1 about 30 cases per year?
2 A I may have at that time, considering how many cases
3 I had seen at that juncture.
4 Q Do you recall a case that was called Loria versus
5 Ratner?
6 A Yes.
7 Q And did you say in that case that you had testified
8 or you had reviewed about 30 cases a year for five or six
9 years?
10 A If that's what's documented in there, that's what I
11 testified to.
12 Q So that's fair?
13 A As I said, depending on -- because I don't have any
14 ongoing list. Even depending on the year or years in

15   relation to when I testified, I may be correct or
16   approximate.
17   Q   All right. So a case like this case, assuming that
18   Mr. Pillersdorf pays you in American money, you've reviewed
19   some records, you've traveled to New York, I guess, from
20   Virginia?
21   A   Yes.
22   Q   You're here all day?
23   A   As of now.
24   Q   You probably came in last night?
25   A   Yes, sir.

0409

1   Q   And you hope to get out tonight?
2   A   Whatever works.
3   Q   Okay. What does a case like this generate in terms
4   of income for Dr. Stabile?
5   A   Well, my charge for courtroom testimony is $3,000.
6   Q $3,000?
7   A   Right.
8   Q   And you pick up the expenses?
9   A   No, that is exclusive of the expenses.
10   Q   So you expect Mr. Pillersdorf to pay your expenses?
11   A   I hope so.
12   Q   And what would they be?
13   A   Well, the hotel room, I saw the bill, was around
14   169, and then I have a flight, and I don't know the exact
15   price because I did it relatively last minute, maybe $400.
16   Q   So let me cut to the chase, Doctor. We're going to
17   bore the jury with this stuff. You said before, I think it
18   was, and you feel free to correct me. I'm old; I don't
19   remember anything anymore. You said something about doing
20   this kind of thing, meaning medical/legal work for like
21   Mr. Pillersdorf is five percent, is that what you said, of
22   your income?
23   A   Yes, in general.
24   Q   What does that amount to? How much money is five
25   percent?

0410

1   A   Do I need to say that? Depending on the year, it
2   can be fifteen to $20,000, depending on how much work I do
3   that year. I'd have to look at my IRS records to see if it
4   was much higher than that. There may have been a year that
5   it was 30,000.
6   Q   Well, if you testified in the Loria case that you
7   reviewed -- let me see what was it again -- 30 cases per year
8   on average and that reviewing a case your charge would be
9   about $800, and that's without testimony; that's just
10   reviewing cases, right?
11   A   Correct.
12   Q   So 30 times 800 would be about $24,000, right?
13   A   Right.
14   Q   For review?
15   A   Right.
16   Q   That's without ever coming to court to testify for

17   people like Mr. Pillersdorf, right?
18   A   Correct.
19   Q   And that would be five percent of your income?
20   A   If my W-2 is 450 to $500,000, correct.
21   Q   All right. So you get materials in this case at
22   some point from Shafran & Mosley, yes?
23   A   Yes, sir.
24   Q   And they sent you deposition transcripts?
25   A   I don't think I had deposition transcripts at that

1   time.
2   Q   They send you videotapes?
3   A   No.
4   Q   DVDs?
5   A   No.
6   Q   Surveillance videos?
7   A   No.
8   Q   Doctor, you read Dr. Lombardi's operative report,
9   correct?
10   A   Yes.
11   Q   And when you read it, did you assume it was true?
12   A   I always assume the medical record, especially an
13   operative report, is true.
14   Q   Because when a doctor's in a hospital and he's
15   dictating the reports on an operative case, he's thinking
16   about the case, he's not thinking about getting sued two
17   years down the road or two and a half years down the road; is
18   that generally the case?
19   A   I would think so.
20   Q   And when you read Dr. Lombardi's operative report
21   in this case, right, he's talking about doing a repair of the
22   peroneus longus and the peroneus brevis, right?
23   A   Correct.
24   Q   He's talking about removing the retinaculum, the
25   roof over the tongue, right?

1   A   Correct.
2   Q   And he's talking about rasping down a bony
3   prominence that's in the area of this sulcus, this groove,
4   right?
5   A   Correct.
6   Q   Now, none of these procedures that he's doing
7   involve repairing a fracture, putting fragments of bone
8   together, correct?
9   A   Correct.
10   Q   And this procedure that Dr. Lombardi is talking
11   about would come under the general heading of elective
12   surgery, right?
13   A   Correct.
14   (Whereupon, Official Court Reporter Mary Benci was
15   relieved by Official Court Reporter Michelle Sheeger.)
16   (Continued on the following page.)
17
18

19
20
21
22
23
24
25
0413
1 Q So your suggestion, I assume, is that in an elective
2 surgery case where you know that the patient is going to have
3 some amount of swelling it's a good idea to allow for the
4 swelling by either putting on a posterior splint with an Ace
5 bandage to keep it on, right, or if you apply a cast you must
6 carefully, perfectly bivalve the cast, right, is that fair?
7 A I think that's fair.
8 Q So if in fact, as Mr. Pillersdorf would say,
9 hypothetically -- so you know what a hypothetical question is?
10 A I have been paying attention today.
11 Q I will ask you to listen to a hypothetical question
12 from me, all right, I am younger than he is I may not know as
13 much but listen to the question, all right?
14 A Yes, sir.
15 Q Did he invite you to his 85th birthday party last week,
16 did you get an invitation?
17 A No.
18 Q It was quite a shindig, cottage cheese and mashed
19 bananas.
20 MR. PILLERSDORF: This is all on the record.
21 Q I want you to assume from this handwritten note right
22 here, which you could see right above Mr. Pillersdorf's head,
23 can you see it from there? If not, I can direct your attention
24 to the hospital record Plaintiff's Exhibit 1 in evidence.
25 A I can see it.
0414
1 Q Excellent.
2 Give me one second, doctor. Judge, please, just one
3 second.
4 Assuming hypothetically, assuming that Dr. Lombardi's
5 note written on the day of surgery, August 23, 2005, assuming
6 it's as true as the operative report that he dictated, just
7 assuming for the sake of argument it's true and he wrote:
8 Patient tolerated procedure. Left OR with vital signs stable/
9 neurovascular status intact. Cast intact, split by residents.
10 Ace applied. Patient to followup in office Thursday.
11 Just assume he is telling the truth, just for argument
12 sake. That would suggest that the residents bivalved the cast
13 in the operating room, yes?
14 A I don't know, either in the operating room or in the
15 PACU, either place.
16 Q Assume that surgeons usually get their butts kicked by
17 nurses, if they use one of these things in a recovery room,
18 right?
19 A Correct.
20 Q You have people recovering, they are trying to sleep it

21 off, you don't start up an eggbeater in a recovery room, yes?
22 A Correct.
23 Q You also, if your mother taught you properly, you don't
24 make a mess with plaster and Fiberglass and bandages on the
25 floor of the recovery room, you do it in the OR which is already
0415
1 a mess, right?
2 A You could do it either place.
3 Q Okay.
4 Assuming that the residents were telling the truth, or
5 rather Dr. Lombardi was telling the truth, that the cast was
6 split by the residents in either the OR or the men's room or
7 wherever it was in the hospital, assuming they bivalved the
8 cast, okay, make that assumption?
9 A Yes.
10 Q If they did that then Dr. Lombardi met the standard of
11 care, whether it was Virginia, Florida, North Carolina, South
12 Carolina or even New York State, yes?
13 A Yes.
14 Q So, you're here and you're basically making a factual
15 determination that the doctor is wrong and the patient is right,
16 the doctor is wrong that the cast was bivalved, the patient is
17 right that it wasn't, true?
18 A True.
19 Q Now, you talked to Mr. Pillersdorf and you told him
20 that people that have a drop foot, they walk in a peculiar way,
21 don't they?
22 A Yes.
23 Q They have to do something to compensate for the
24 weakness of the muscles that are on the anterior and lateral
25 aspect of their lower leg, right?
0416
1 A Right.
2 Q And one can do that by using the thigh muscles, picking
3 the leg up, right?
4 A That's usually what they have to did.
5 Q They don't have much choice, do they?
6 A No.
7 Q You called that a steppage gait, right?
8 A Correct.
9 Q And being a competent podiatrist, if a patient walked
10 by you in your hallway of your office you could tell whether
11 they had a steppage gait or not, right?
12 A If they had a true steppage gait it would be obvious.
13 Q Right.
14 And if the patient was wearing an appliance you could
15 see it, right?
16 A Not necessarily.
17 Q Okay.
18 Supposed the patient had pants up, they don't call them
19 pedal pushers anymore my wife tells me, they have another name,
20 I don't know, capri pants, something like that, or a skirt, if a
21 patient had their legs exposed you could tell, right, whether
22 they had an appliance on?

23 A Correct.
24 Q Without a device, a device, to compensate for the
25 inability to plantar flex and dorsiflex the ankle, a person with
0417
1 a drop foot is going to have a steppage gait, right?
2 A It depends on the amount of weakness, because there can
3 be different levels of weakness resulting in a drop foot, so
4 that you could have mild weakness that it's not very apparent,
5 or the typical significant weakness that you have the steppage
6 gait. So it's not an always or never.
7 Q Okay.
8 In your review of the materials in this case you looked
9 at the records of Rina Caprarella, yes?
10 A Yes.
11 Q And she's part of a group, I gather, that's called Pro
12 Health, something like that?
13 A Correct.
14 Q And I got the impression, you may agree with me you may
15 not but I guess you'll tell me, there are a bunch of doctors
16 that are associated with Pro Health, they are a group, right?
17 A That appears to be the case, yes.
18 Q There's a Dr. Hainline, who's some sort of a
19 neurologist that Ms. Licitra knew from playing tennis at the
20 Douglaston Club who referred her to Dr. Caprarella, right?
21 A Correct.
22 Q They have pain management people, they have
23 orthopedists Dr. Gazzaniga, right?
24 A Right.
25 Q They have Dr. Millman, right?
0418
1 A Correct.
2 Q They have lots of people.
3 And groups like Pro Health make money by seeing
4 patients, right?
5 A As anybody working.
6 Q That's a truism, isn't it?
7 A Sure.
8 Q Doctors make money by treating patients, right?
9 A Absolutely.
10 Q Right.
11 And it's not uncommon in a group for one physician to
12 refer a patient to their colleague in the same group, right?
13 A Correct.
14 Q And the doctors of various specialties have input
15 that's peculiar to their expertise, for instance you are a
16 podiatrist, you're not a neurologist, that's true, right?
17 A Correct.
18 Q There are things that neurologists are trained to look
19 for that you're not?
20 A Correct.
21 Q There are things that neurologists are expert about
22 that you're not?
23 A Well, let me rephrase that. In relation to foot and
24 ankle we have a significant amount of experience as podiatrists,

25   but you're right, overall I could defer to them, their
0419
 1   experience and knowledge.
 2   Q   Well, you were talking with Mr. Pillersdorf about
 3   nerves, and nerves in the lower extremity is something that are
 4   peculiarly within the competence and practice of the podiatry
 5   profession, right?
 6   A   Correct.
 7   Q   Right.
 8   And if you wanted to take somebody's pulses you put
 9   your fingers -- not pulses, if you wanted to check somebody's
10   nervous supply you palpate an area and you might get a response
11   that would surprise you, right?
12   A   Correct.
13   Q   And for instance, did you notice in any of the medical
14   reports having to do with Ms. Licitra, nice lady sitting out
15   there patiently listening to me, that when she was examined she
16   had absent ankle reflexes, did you notice that?
17   A   Correct.
18   Q   Well, would it be a leap, a leap of logical reasoning,
19   for me to say that if Dr. Caprarella found that Ms. Licitra had
20   absent ankle reflexes in both legs that it had nothing to do
21   with anything that Dr. Lombardi did or didn't do?
22   A   Well, that may be true, correct.
23   Q   Well, could it be otherwise, do you think?
24   A   If she found a lack of ankle reflexes on her
25   examination in both extremities she found it, that's remarkable.
0420
 1   Q   Right.
 2   And it wouldn't have anything to do with peroneal
 3   tendon surgery on the left lower extremity, would it?
 4   A   You'd have to ask Dr. Caprarella, but the lack of
 5   reflexes in an extremity that's affected with a drop foot can be
 6   a result of nerve damage as well.
 7   Q   Right.
 8   So if the patient has absent ankle reflexes in the
 9   right lower extremity, the right ankle, but had surgery on the
10   left ankle are you telling me that there's a competent producing
11   cause that could cause that?
12   A   You're picking out one part of a thorough neurologic
13   exam to determine --
14   Q   But I am going somewhere, I am. I am going one point
15   at a time. I am saying to you that if Ms. Licitra had absent
16   ankle reflexes bilaterally in October of 2005 when she was seen
17   by Dr. Caprarella it had absolutely nothing to do with Dr.
18   Lombardi's surgery, would you agree with that?
19   A   No, no, absolutely not. You'd have to -- you know, you
20   can't split the pairs and say the drop foot or the common
21   peroneal nerve injury had nothing or no influence there. You
22   don't know.
23   Q   Tell me why Ms. Licitra had absent ankle reflexes on
24   the right side?
25   MR. PILLERSDORF: I was going to object but --
0421

1 THE COURT: Overruled.
2 You may answer.
3 A I will defer to Dr. Caprarella to answer that question.
4 Q Let me go at it a different way. The nerves that
5 enervate the muscles in the foot, they all originate in the
6 spinal cord, don't they?
7 A Correct.
8 Q And if we were talking about peroneal muscle
9 innervation we would be talking about the low back, the low
10 spine, yes?
11 A Yes.
12 Q And if I said to you that our spinal cord has different
13 segments is the lumbar segments and it's L1 through L5, right?
14 A Right.
15 Q Then below that we have the sacral portion of the
16 spinal cord S1, the nerves that control the muscles on the
17 lateral aspect of the leg and the front come out of L5-S1,
18 right?
19 A Right.
20 Q And early on in Dr. Caprarella's workup of Ms. Licitra
21 she makes a note that says --
22 MR. PILLERSDORF: Object, your Honor. It's not in
23 evidence. If Dr. Caprarella's here, but they are
24 cross-examining someone on material I wasn't allowed to go
25 into some of her findings, she'll be here Monday.

1 MR. HELLER: I am not reading anything from
2 evidence, I am asking this doctor if he reviewed Dr.
3 Caprarella's records, and he already said he did, and the
4 question is if this lady has a nerve interference because
5 of surgery or perhaps because of something else, I think
6 that's a fair subject, your Honor.
7 THE COURT: I will allow it.
8 Do you remember the question?
9 THE WITNESS: Yes.
10 THE COURT: And your answer?
11 A My answer is --
12 Q I didn't finish the question.
13 THE COURT: You did finish the question.
14 MR. HELLER: I don't know, Judge, I am old I can't
15 recall what I said. Can I ask it again?
16 THE COURT: Yes.
17 Q Doctor, I want you to assume that you have read Dr.
18 Caprarella's chart, as you say you have, and there's an entry by
19 Dr. Caprarella early on that she wants to get an MRI of the
20 lumbar spine so that she can rule out an interference, a
21 problem, at the spinal level that could be causing symptoms in
22 the foot and leg, you are aware of that, right?
23 A Right.
24 Q Did you ever see in Dr. Caprarella's record or the
25 record of Pro Health, whatever they are called the group, an MRI

1 of the lumbar spine?
2 A No.

3 Q Human body is not necessarily perfectly symmetrical, is
4 it? Is that a baffling question, you're making faces?
5 A I am answering.
6 Q Okay.
7 A In general we're relatively symmetrical, but I'd have
8 to say nothing's perfect.
9 Q Right. There may be jurors in this juryroom as we're
10 talking that have one foot that's slightly larger than the
11 other, have you ever heard of such a thing?
12 A Yes.
13 Q Being a podiatrist?
14 A Yes.
15 Q You examine both feet, right, all the time, don't you?
16 A Every time, if it's there.
17 Q Yeah, sure.
18 There are no right foot specialists or left foot
19 specialists, you can do either foot, right?
20 A Yes.
21 Q My right leg might be somewhat bigger in circumference
22 than my left, true?
23 A Could be.
24 Q And there are people if you measure the length of their
25 hip from the iliac crest to the bottom of their foot one can be

0424

1 longer than the other by a centimeter and it would still be
2 normal, right?
3 A It wouldn't be normal, it would be a limb length
4 discrepancy, but it would be a possibility.
5 Q How about common?
6 A I don't -- well, in thousands of patients that I've
7 seen I maybe have seen a handful that have limb length, so
8 that's not real common.
9 Q Are you a New York Yankee fan?
10 MR. PILLERSDORF: I object as irrelevant at 3:20 on
11 Friday.
12 THE COURT: Let's move on.
13 MR. HELLER: I was going to talk about a triple
14 play, the first in 42 years.
15 THE COURT: Yes, we all heard about that.
16 Q That's rare?
17 THE COURT: Next question.
18 Q Doctor, let's go on to something productive. Have you
19 looked at Dr. Lombardi's x-rays? He's not going to tell you, it
20 may be in the chart there in front of you.
21 A I don't remember looking at them.
22 MR. HELLER: May I approach, your Honor?
23 THE COURT: You may.
24 X-ray reports or x-rays?
25 MR. HELLER: X-rays, films. I don't see them

0425

1 here -- yes, I do, I lied.
2 Q Film number one doctor, from Plaintiff's Exhibit 2 in
3 evidence, is a lateral of the plaintiff's foot, correct?
4 A Yes.

5 Q Do you need a box or can you look at the natural light
6 and be able to tell us what you see? I will ask you a question,
7 can you review that or do you need a shadowbox?
8 A I can review.
9 Q Is it true that the patient has hammer toes of some of
10 the lesser digits?
11 A Yes.
12 Q Is it true that the patient has a high arched foot?
13 A I would call it moderate.
14 Q Say again?
15 A Moderate to high arched foot.
16 Q All right.
17 And doctor, I will show you what I think is an AP view.
18 AP view, yes?
19 A Yes.
20 Q Does the patient have a bunion deformity or more
21 properly a hallucis abductovalgus deformity?
22 A Yes.
23 Q If I say hallucis abductovalgus deformity, I show you
24 this dirty skeleton, and the metatarsal which is the big bone in
25 the forefoot goes in this case to the right, and the toe goes

1 the other way?
2 A Correct.
3 Q That's basically -- and there may be a rotary
4 component, may or may not, yes?
5 A Yes.
6 Q Does the patient have something of a hallucis
7 abductovalgus deformity?
8 A Yes.
9 Q You noticed, I assume, that over the years Ms. Licitra
10 was seen repeatedly for podiatric care?
11 A Correct.
12 Q And you've looked at the records of Dr. Barnie Martin?
13 A Yes.
14 Q The records of Dr. Gudeon?
15 A Yes.
16 Q Delacourt?
17 A Yes.
18 Q Alietti?
19 A I don't remember -- I know the name, I may of seen
20 them, I may not of.
21 Q Dr. Aglietti's record, Plaintiff's Exhibit 11 in
22 evidence.
23 THE COURT OFFICER: (Handing.)
24 THE WITNESS: Thank you.
25 Q Doctor, I will put the x-ray back in the folder for a

1 second, all right?
2 THE COURT OFFICER: I'll do that.
3 MR. HELLER: You'll do that, okay.
4 May I approach for a second, your Honor?
5 THE COURT: Yes.
6 MR. HELLER: Thank you.

7 Q Doctor, the first entry in this record is April 27,
8 1998, yes?
9 A Correct.
10 Q And I assume that podiatrists take histories when they
11 see a patient for the first time, correct?
12 A They should.
13 Q That would be standard of care in Virginia as well as
14 anywhere else?
15 A All 50 states.
16 Q Do you notice it says chief complaint: Dropped met
17 times 35 years. Arrow to the right. It says DEB right below
18 where it says physician Restivo?
19 A Can you show that to me, is that on the 27th? Maybe I
20 am not seeing it right.
21 Q You're on the wrong page.
22 A Oh. Pardon me.
23 Q Sure.
24 You see where I am pointing or talking about?
25 A Restivo correct.
0428
1 Q Right below it, it says: Dropped met times 35 years,
2 you see that?
3 A Correct.
4 Q And then it says: Fracture left foot status post seven
5 years, you see that?
6 A Yes.
7 Q Were you aware of the fact that Ms. Licitra had a
8 fractured foot seven years before '98, which would have been
9 '91?
10 A '92, no.
11 Q '92?
12 A Oops, '91. My mistake.
13 Q That's Virginia, okay I understand, we'll make
14 allowance.
15 This lady apparently takes a history and the patient is
16 complaining of various types of problems including heel pain,
17 yes?
18 A Correct.
19 Q And there's all kinds of information, but essentially
20 she has pain on the bottom of her toes -- bottom of her feet,
21 excuse me, and this doctor basically finds that she's got
22 digital contractures, right?
23 A Correct.
24 Q You tell me if I am wrong, but if somebody has a claw
25 toe deformity or hammer toe deformity, that's what we're talking
0429
1 about when we talk about digital contractures?
2 A Yes.
3 Q You call this the distal interphalangeal joint?
4 A Yes.
5 Q As opposed to the proximal?
6 A Correct.
7 Q If they have hammer toes or claw toes and they walk
8 with hammer toes or claw does that cause a force back on the

9 toes and cause pain?
10 A Yes, when someone has hammer toe deformity the toes
11 will cause pain and pressure and possible callous on the ball of
12 the foot.
13 Q Right.
14 Would it be fair to say that in your review of all
15 these chart materials that we have on the table Dr. Aglietti,
16 Dr. Gudeon, Dr. Delacourt, Dr. Barnie Martin, if I said to you
17 they are all podiatrists and none of them did surgery to fix
18 this deformity would you agree with me?
19 A Yes.
20 Q As a result of the type of foot that this lady had, she
21 has a moderately high arched, she's got digital contractures on
22 at least some of her toes, and she's got a moderate HAV
23 deformity, right?
24 A Right.
25 Q I am pointing to the right hand, but I mean the left.
0430
1 She may be more susceptible or less susceptible to an
2 injury as a result of overuse than other people, right?
3 A Absolutely, with foot deformities any overuse can cause
4 injury.
5 Q Right.
6 So I want you to assume that while you were sitting out
7 in the hallway this morning on the bench, Ms. Licitra was in
8 your seat and she said that before she had surgery by Dr.
9 Lombardi, before she learned that she had a tendon tear, before
10 she learned those things, she liked to play tennis. She played,
11 I think she said she had a game three times a week, and
12 sometimes she played on weekends. She was an avid tennis
13 player, right?
14 A Absolutely.
15 Q Have you heard of a syndrome in sports, podiatric
16 medicine, that's known as overuse?
17 A That's a general sports medicine term. Actually you
18 don't even have to do sports to have overuse injury.
19 Q So you have heard of it in Virginia?
20 A Yes.
21 Q All right.
22 There are people, I gather, who overdo it, right?
23 A Anybody can, sure.
24 Q Right.
25 And when you do -- when you play tennis you usually do
0431
1 it -- you ever play tennis?
2 A Yes.
3 Q He doesn't, he doesn't play tennis.
4 You play tennis you have to be kind of quick on your
5 feet, and you have to have lateral ability, lateral movement,
6 right?
7 A Correct.
8 Q All right.
9 And if you play, often you put certain stress on your
10 ankles, on your feet, on your toes, correct?

11 A Both feet.
12 Q Right.
13 A Correct.
14 Q And if I suggested to you that as we follow Ms.
15 Licitra's history, podiatric history, up to and including
16 2005 -- you with me here?
17 A Yes.
18 Q When you look at the paper I am not sure --
19 A I am listening.
20 Q When we followed her history we see a pattern of
21 problems with her foot and ankle that relate to sports,
22 instability, right?
23 A I don't know if instability's the right word. She
24 talks about swelling and pain but she testified to playing two
25 to two and-a-half hours of tennis three days a week, that's an
0432
1 overuse but -- what is an indication of instability on the
2 record?
3 Q Okay, she's got pain and swelling from playing two to
4 two and-a-half hours three times a week, right?
5 A Correct.
6 Q All right.
7 And she comes to Dr. Lombardi and she gives him this
8 history that basically talks about lateral foot pain on the left
9 foot, she talks --
10 A Correct.
11 Q You're making faces.
12 A I didn't know if I was supposed to answer.
13 Q She talks about a box falling on her foot. But in all
14 likelihood if she had a tearing or a tendinosis of the peroneal
15 tendons, it wasn't from a box falling on her foot, would you
16 agree with that?
17 A I have no idea, I don't know the size or the weight of
18 the box or the type of injury.
19 Q You don't know whether it was a brown box, a white box
20 or it was wrapped up in string, right, does it matter? Isn't
21 it likely that Ms. Licitra had a tendinosis from repeated stress
22 to the area from sports?
23 A That could be true.
24 Q She comes to Dr. Lombardi and she's really not enjoying
25 playing tennis because she's got this pain and swelling, right?
0433
1 A That's what I understand.
2 Q And as I understood your testimony the surgery was
3 indicated, right?
4 A Yes.
5 Q And he did it properly, right?
6 A According to what I saw, absolutely.
7 Q Neither of us was there when he did the surgery, we're
8 just able to look at records and listen to testimony, read
9 testimony, correct?
10 A Correct.
11 Q That's always the way it is for you when you are a
12 medical legal consultant, you're not an eyewitness, are you?

13   A   No.
14   Q   All right.
15   So Dr. Lombardi does this surgery, and the issue in
16   this case before this jury has to do with the application of a
17   cast, right?
18   A   Correct.
19   Q   Now, there are lots of articles that are written about
20   tendon repairs and casting, yes, you are a guy who reads medical
21   literature?
22   A   Correct. But you have to understand the timeframe --
23   Q   I didn't ask you a question, but okay, I will
24   understand the timeframe, if you want.
25   Are you familiar with this book Foot and Ankle Clinics?

1   A   I am familiar with Foot and Ankle Clinics.
2   Q   Do you consider it to be an authoritative source?
3   A   I think -- I don't know if authoritative is the correct
4   word, it's a referral source that has good information for
5   practice and learning.
6   Q   But not authoritative?
7   A   Authoritative is a difficult word that sounds also like
8   the always and never.
9   Q   Surgery of the Foot and Ankle, this is a heavy book,
10   you know, I should get a reward for carrying it around, but
11   Surgery of the Foot and Ankle, and it's written by a bunch of
12   orthopedists, Coughlin, Mann, Charles L. Saltzman?
13   A   Correct.
14   Q   Is this authoritative in the area of surgery of the
15   foot and ankle?
16   A   Well, once again I think authoritative, to me, my
17   interpretation, it's an always or never, that every word in that
18   is absolutely what is perfectly true.
19   Q   Well, there are various chapters written by various
20   people?
21   A   Correct.
22   Q   Are you familiar with this book?
23   A   I am not familiar -- I am familiar with that book but I
24   have not read it.
25   Q   If I said to you there's a chapter -- lots of

1   chapters -- leave that alone.
2   Foot and Ankle Surgery, this is a podiatric book,
3   Banks, Downey. They are from Philadelphia, Michael Downey, big
4   fat guy. You don't have to agree with that, he will punch you
5   out when he sees you.
6   A   I went to school with him, I know him well.
7   Q   He is an authority in the area of tendon injury?
8   A   He is a knowledgeable fellow.
9   MR. HELLER: Getting closer, judge.
10   Q   Are you familiar with a chapter that's entitled muscle
11   tendon surgery and tendon transfer?
12   A   I am familiar with the book, so I would agree I would
13   have some familiarity with that chapter. I can't quote anything
14   from it.

15 Q Would you consider it to be authoritative?
16 A Once again, I think authoritative is a very strong word
17 in an always and never situation. I think it's a guide for
18 learning and practice.
19 Q Doctor, if I said to you that each one of these books
20 advocates putting the foot in a cast following tendon repair
21 would you be surprised?
22 MR. PILLERSDORF: I will object your Honor.
23 THE COURT: Sustained.
24 MR. PILLERSDORF: Thank you.
25 Q Doctor, as a general proposition aren't there many,
0436
1 many foot and ankle surgeons in this country that put foot and
2 ankle tendon repairs in a cast?
3 A Not immediately after surgery.
4 Q You can wait 24 hours for the swelling to go down and
5 then they cast it?
6 A Typically two days, as we're taught in both medical
7 school and residency training.
8 MR. HELLER: Can I just get some water?
9 THE WITNESS: Me too.
10 Q Doctor, are there certain types of foot and ankle
11 surgery that must be casted?
12 A Yes.
13 Q For instance --
14 A Well, let me ask you a question --
15 Q Let me rephrase the question. Trauma cases, patient
16 comes in with an evulsion fracture of the talus, does it have to
17 be casted?
18 A If there's no surgery involved at some point cast
19 immobilization is needed.
20 Q Patient falls 30 feet off a fire escape and has
21 multiple fractures to calcaneus, surgery is done to reduce the
22 fractures, does it have to be casted?
23 A It has to be casted, but you don't put a cast on right
24 at the end of the surgery.
25 Q Patient has a club foot repair, does it have to be
0437
1 casted?
2 A It typically has to be casted.
3 Q Posterior splints, does it make any difference whether
4 the posterior splint is fabricated from the back half of the
5 cast or whether it's fabricated from sheets of Fiberglass that
6 the podiatrist puts through some water, molds onto the patient's
7 foot and wraps it around with Ace bandage, right?
8 A If you are accomplishing fabricating or creating the
9 posterior splint to stabilize it, whatever material is available
10 that you can accomplish that, I have no problem with that.
11 Q When Dr. Caprarella first sees Ms. Licitra she examines
12 her and as a competent neurologist she finds that this 63 year
13 old lady, a young 63, has dorsiflexion strength of 0 over 5, can
14 you assume that for a second, are you with me?
15 A I am reading it, correct.
16 Q Just assume it for a second.

17   A   Yes.
18   Q   When we talk about dorsiflexion --
19   MR. HELLER: Your Honor, may I approach the
20   witness?
21   THE COURT: Yes.
22   Q   This is clean. (Handing.)
23   Fair and accurate, plastic model of the human foot?
24   A   Very much.
25   Q   Just demonstrate for the jury dorsiflexion.

1   A   Dorsiflexion means for you to tell your foot, through
2   your brain, tells the nerves to activate the muscles to make the
3   foot go up.
4   Q   And plantar flexion?
5   A   The opposite direction, like pushing on a gas pedal.
6   Q   If I said to you that eversion with an "E" means that
7   we're putting weight on the big toe, is that correct, on the
8   left foot like this, correct?
9   A   Yes.
10   Q   And inversion means we're putting weight on the outside
11   of the foot, is that right?
12   A   Correct.
13   Q   Dr. Caprarella, when she first sees the patient, finds
14   that she's got 0 over 5 dorsiflexion strength, assume that,
15   right?
16   A   That's what she states, correct.
17   Q   That's not a good thing, is it?
18   A   That's bad.
19   Q   It's bad, right?
20   A   Terrible.
21   Q   That suggests that Ms. Licitra had some sort of a nerve
22   injury prior to the visit with Dr. Caprarella, right?
23   A   Correct.
24   Q   And I want you to assume that Ms. Licitra continues to
25   be seen by Dr. Caprarella over the next months and years, is

1   that fair?
2   A   That's true.
3   Q   Right.
4   So that by approximately November of 2005 Dr.
5   Caprarella, who is recording her examinations, right, says that
6   Ms. Licitra then has improved strength with dorsiflexion, it's
7   now 5 minus over 5, all right?
8   A   Correct.
9   Q   That's a dramatic difference from 0 over 5, correct?
10   A   Correct.
11   Q   5 minus over 5 is almost full strength, right?
12   A   It's close.
13   Q   Right.
14   So when you were talking with Mr. Pillersdorf earlier,
15   one of the topics was is nerve injury permanent, and you said
16   well, you know, it can be it, doesn't have to be, in rare
17   instances the patient gets full recovery or almost full,
18   something like that, right?

19   A   Correct.
20   Q   Yeah.
21   So if you were to look at the dorsiflexory strength of
22   Ms. Licitra's left foot as recorded by Dr. Caprarella between
23   the initial visit and a month later it would seem that there was
24   a dramatic change in dorsiflexory strength, right?
25   A   Absolutely.
0440
 1   Q   That would have to relate to a response by nerve
 2   tissue, yes?
 3   A   I would say the nerve function is improved.
 4   Q   Dramatically, right?
 5   A   Fortunately.
 6   Q   Fortunately, yes. Fortunately sure, but also
 7   dramatically, right?
 8   A   Correct.
 9   Q   What would you have to see -- withdrawn.
10   Dr. Caprarella is also measuring -- can I borrow my
11   skeleton back for a minute, doctor?
12   A   You can have it (Handing.)
13   Q   Dr. Caprarella is also measuring -- you have to look at
14   me, doctor, otherwise I am lost. You with me?
15   Dr. Caprarella is also measuring the strength of
16   evertors and the strength of inverters, right?
17   A   Correct.
18   Q   And she's finding that the strength is at least four, 4
19   plus over 5, 5 minus over 5 of the left foot, right?
20   A   Correct.
21   Q   So that there's a dramatic increase and a dramatic
22   improvement, a fourth un-improvement in Ms. Licitra's ability to
23   dorsiflex, invert, evert her foot between October whenever the
24   first visit with Caprarella is and the end of November,
25   Thanksgiving time, yes?
0441
 1   A   True.
 2   Q   And would you agree that to some extent that suggests
 3   that the injury, whatever the damage was to the nerve, was not
 4   permanent, it was temporary?
 5   A   But that gets contraindicated later in Dr. Millman's
 6   evaluation years later. So it's hard -- --
 7   Q   Doctor, if we limit our answer for the moment, limit
 8   your answer, without traveling into the future yet, if you limit
 9   your answer to Dr. Caprarella's records between October 20
10   something and November 29th of 2005 don't they evidence a
11   dramatic improvement in the lady's ability to dorsiflex, invert,
12   evert, her foot?
13   A   Yes.
14   Q   And those are all a function of the return of nerve
15   function?
16   A   Correct.
17   Q   There are articles in podiatric journals that talk
18   about people who develop a neuropraxia, which is an injury to a
19   nerve, that's not permanent, right?
20   A   Typically not permanent.

21 Q There are articles about people who sit in airlines,
22 airliners, planes, you know, and they may have their feet pigeon
23 toed, or they may have them this way, because they are squished
24 they make the seats so small these days and you have to put your
25 carryon stuff under your seat, so if somebody sits on an

1 airliner for hours they may wind up with a neuropraxia, right?
2 A True.
3 Q There are articles about people that squat or kneel or
4 do yoga and they wind up in a lotus position that causes a nerve
5 injury, right?
6 A Correct.
7 Q And there are articles about people that fall asleep
8 with their cast on or their cam walker and they wind up with a
9 neuropraxia, right?
10 A I am not familiar with any.
11 Q Doctor, there's an article in a journal called -- the
12 Journal of Foot and Ankle Surgery, that's one of your podiatric
13 journals, yes?
14 A Correct.
15 Q And it was in the 2009, issue by the American College
16 of Foot and Ankle surgeons, that is your organization, right?
17 A Correct.
18 Q Dr. Lombardi's also, right?
19 A Correct.
20 Q And it's by two podiatrists Chad Mormon and Jane
21 Pontias, are you familiar with it?
22 A I am not familiar with the article, I know who Jane is.
23 MR. PILLERSDORF: He is not familiar and it's not
24 authoritative, I ask that he move on.
25 MR. HELLER: I am getting around to asking a

1 question, Judge.
2 Q Doctor, can I have it back for a minute?
3 MR. HELLER: Would you like to see it?
4 MR. PILLERSDORF: No, I don't really want to see
5 it to be honest with you. I object to it being used unless
6 the proper foundation is there.
7 MR. HELLER: I am going to try.
8 Q Doctor, the article that's entitled compression
9 peroneal nerve palsy causing isolated extensor hallucis longus
10 dysfunction, keep you up at night. This article, would you
11 consider it to be authoritative in the area of peroneal nerve
12 palsy, yes or no?
13 A No.
14 (The following is transcribed by Mary Benci.)
15 (Continued on next page.)
16 * * * *
17
18
19
20
21
22

23
24
25
0444
1 CROSS-EXAMINATION (Continued)
2 BY MR. HELLER:
3 Q Doctor, do you happen to know where the operating
4 room that Dr. Lombardi did his surgery in was located in
5 reference to the PACU, in other words, the post anesthesia
6 care unit, the recovery unit, how far apart were there?
7 A I have no idea.
8 Q In some hospitals, they could be as close as 20
9 feet away, right?
10 A Absolutely.
11 Q And it they were that close --
12 MR. PILLERSDORF: Objection, your Honor. It's
13 hypothetical, and they also could be on another floor
14 or they could be in the same room. If he doesn't
15 know what it is in this hospital, what difference does
16 it make. Objection. I'm sorry, I shouldn't make a
17 speech.
18 MR. HELLER: No, he's entitled, your Honor. It's
19 late in the day.
20 THE COURT: Question.
21 Q Assuming, hypothetically, that Dr. Lombardi always
22 used operating room two, because it was set up for podiatry
23 as opposed to brain surgery, childbirth, and that
24 Dr. Lombardi's operating room, number two, was within 20 or
25 30 feet from the post anesthesia care unit, could you assume
0445
1 that for a minute?
2 MR. PILLERSDORF: Assumes facts not in evidence.
3 THE COURT: Overruled.
4 Q Just assume that for me.
5 A Yes.
6 Q It would take no more than ten or twenty seconds to
7 roll the gurney out of the OR to the PACU, correct?
8 A Correct.
9 Q Dr. Lombardi runs a residency program; you're aware
10 of that, right?
11 A Yes.
12 Q Got out of school a few years ahead of you, same
13 school, right?
14 A Correct.
15 Q Competent podiatric school, the Pennsylvania
16 College?
17 A Yes.
18 Q They didn't train boobs, right; they train good
19 doctors, right?
20 A Absolutely.
21 Q And he did a residency following his graduation and
22 after his residency he became Board certified and he has
23 hospital privileges, runs a residency program and he's been
24 operating as a podiatrist since, I don't know, 1985, about 25

25   years. Assume those things.
0446
 1   A   I understand that, correct.
 2   Q   Right. He did, according to you, the surgery
 3   properly, right?
 4   A   Yes.
 5   Q   For an indicated reason, right?
 6   A   Right.
 7   Q   Do you have any doubt that he understands how to
 8   bivalve a cast?
 9   MR. PILLERSDORF: Objection.
10   THE COURT: Overruled.
11   Q   That's my question.
12   THE COURT: You may answer.
13   A   No, no.
14   Q   You don't doubt it, do you?
15   A   I don't doubt that.
16   Q   A doctor who operates for 25 years at his level,
17   hospital privileges, running a residency program, testifies
18   at his deposition or at least one of the nurses testified
19   in her deposition that she's operated with him 100 to 200
20   times?
21   A   Correct.
22   Q   Has put on innumerable casts in 25 years, right?
23   A   Right.
24   Q   He should no how to bivalve a cast, right?
25   A   Yes.
0447
 1   Q   Doesn't need somebody like you to tell him how to
 2   do it on the day of surgery, right, knows how?
 3   A   I hope not.
 4   Q   Can somebody with a true foot drop play tennis?
 5   A   As I said earlier, there's different levels of
 6   weakness in foot drop. If you have a brace that helps
 7   support the foot in a mildly weakened foot, I could see a
 8   person playing tennis with a drop foot.
 9   Q   Doctor, I'm going to hand you a box that's blue and
10   white.
11   MR. HELLER: May I, your Honor?
12   THE COURT: You may.
13   Q   Tell me what's in it, sir (handing).
14   A   This is an ankle brace from Aircast, is the name of
15   the company.
16   Q   Just like Ace bandages, the Ace is a proprietary
17   name, right?
18   A   Yes.
19   Q   Aircast is the name of a company, right?
20   A   And doubles for the device, too.
21   Q   Right. So this is Mr. Pillersdorf's skeleton.
22   MR. PILLERSDORF: The dirty one.
23   MR. HELLER: The dirty one.
24   Q   It's not his mother-in-law. It's some unknown
25   person. Show us how the air cast goes on. I feel like I'm
0448

1 assisting in surgery.
2 A So you would typically use it to support the back
3 part of the foot, more commonly for ankle instability. But
4 it also has some effect to stabilize the foot and ankle.
5 Q All right. So this air cast is now on, and we see
6 that the padded portion runs up the medial and the lateral
7 aspects of the ankle, right?
8 A Right.
9 Q They don't do anything about dorsiflexion or
10 plantar flexion?
11 A It is a slight help because it's supporting the
12 heel.
13 Q This is not a brace for drop foot, true?
14 A True.
15 Q Is it okay if I take this off here?
16 A Fine.
17 Q Just help me with this.
18 If you have a true drop foot, an air cast is not
19 going to permit you to play tennis, right?
20 A As I stated earlier, it depends on how much
21 weakness. If a person hypothetically has mild weakness, or
22 enough strength, even though they do not have normal
23 strength, maybe enough for them to play some level of tennis.
24 MR. HELLER: Officer, would you hand that to the
25 witness.
0449
1 COURT OFFICER: (Handing.)
2 Q That's a whole other appliance, isn't it, Doctor?
3 A Yes.
4 Q And what is that?
5 A This is called an AFO, which is considered an ankle
6 foot orthosis.
7 Q And if in fact you had a legitimate drop foot and
8 it was a right foot -- is that right foot or left foot? I
9 can't tell.
10 A It's right foot.
11 Q And it was right foot, you would need something
12 like that, right?
13 A Let me qualify that. You say legitimate.
14 Q Let me rephrase the question. If you had a true
15 drop foot, and you had zero over five ability to dorsiflex
16 and plantar flex, you would need an ankle foot orthoses like
17 that to deal with your drop foot, yes?
18 A To walk, correct.
19 Q Could you play tennis with this?
20 A I don't know. I haven't seen anybody with this
21 play tennis. It would probably be difficult, but athletes
22 overcome difficulties every day.
23 Q Have you seen any evidence in the records of
24 Dr. Gudeon, and Dr. Delacourt and Dr. Caprarella that
25 Ms. Licitra was playing tennis wearing an AFO?
0450
1 A No.
2 THE COURT: How are you doing, members of the jury?

3 Are you okay?
4 THE JURORS: Yes.
5 Q Doctor, people as they get older develop
6 degenerative joint disease often?
7 A True.
8 Q Degenerative joint disease can affect the feet?
9 A Very often.
10 Q Can affect any joint, but you're a podiatrist so
11 I'll talk to you about feet rather than hands, fair?
12 A Fair.
13 Q Degenerative joint disease is painful, yes?
14 A Can be.
15 Q And as the years go on, it doesn't usually get
16 better, it gets worse, right?
17 A Correct.
18 Q Degenerative joint disease can cause pain when you
19 run, right?
20 A Right.
21 Q Can cause pain when you go upstairs or downstairs,
22 yes?
23 A Yes.
24 Q And in fact -- withdrawn.
25 Do you know what a bone scan is?

1 A Yes, sir.
2 Q And as a podiatrist, from time to time you've
3 ordered bone scans, right?
4 A Right.
5 Q And if I said to you they're a test that's very
6 sensitive, but very nonspecific, would you agree with me?
7 A Yes.
8 Q And when you talk about a bone scan, and I'll be
9 simple about it because I'm simple, you're injecting or a
10 pain management, somebody who is a medical doctor, usually, a
11 radiologist is injecting a radioactive tracer element,
12 usually Technetium or something like that, into the person's
13 bloodstream, right?
14 A Yes.
15 Q And then they're put either under an X-ray or a
16 machine that can trace where the radioactive tracer element
17 goes, right?
18 A Correct, yes.
19 Q And the significance or the use of the bone scan is
20 that the blood can be traced, can be tracked where it's
21 going, right? In other words, the scan will light up, it
22 will show evidence of the Technetium in any area where
23 there's bony activity going on; is that true?
24 A Yes, correct.
25 Q Is that true?

1 A Yes.
2 Q If in fact you have degenerative joint disease in
3 your feet, you might expect the bone scan to light up in the
4 area where you have degenerative joint disease, right?

5 A Absolutely.
6 Q Somebody that has claw toes or hammertoes, that's
7 an almost pathognomonic for degenerative joint disease,
8 right?
9 A That's a positional problem.
10 Q Right.
11 A So without X-ray evidence of the degenerative joint
12 disease, that it can be information, but, no, I mean it's
13 something.
14 Q If you have hammertoes or mallet toes or claw toes,
15 contracture of the forefoot that was constantly being
16 aggravated by tennis, would you be surprised to see a bone
17 scan light up in the area of those digits?
18 A No.
19 Q It would be expected, right; it wouldn't be
20 surprising, right?
21 A Right.
22 Q You have over the past twenty some odd years
23 operated on hundreds of patients?
24 A Yes.
25 Q How many surgeries do you do a year?
0453
1 A I don't count. As I've testified earlier, I do
2 cases particularly every Wednesday, two to five cases. So
3 three times -- 150 to 200 surgeries a year is probably a fair
4 estimate.
5 Q A hundred fifty to 200, is it?
6 A Yes.
7 Q All right, that's fair. And if you were sitting
8 here today and you do 150 to 200 surgeries a year, are many
9 of them -- they're all foot surgeries, I assume, right?
10 A Foot or ankle. Foot or ankle is my scope.
11 Q All right. Hundred and fifty to 200 surgeries a
12 year, and if I took you back five years you would have done
13 750 to 1,000 surgeries, right?
14 A Yes.
15 Q And if I asked you to recall a surgery that you did
16 on Mrs. Jones, June 1st, 2006, would you have any way of
17 remembering?
18 A I would only have the ability to review the
19 records, and if there's some reason I had any additional
20 information I'd just have to rely on the records.
21 Q And in fact, would you be surprised if the nursing
22 personnel in the ORs and the recovery room didn't remember
23 the case either?
24 A I wouldn't be surprised.
25 Q You wouldn't expect them to, would you?
0454
1 A I don't think there's any reason why they should
2 remember it.
3 Q Right. And every year of your 150 to 200 patients,
4 you sit down with them and you talk to them and you say,
5 Mrs. Jones, I'm about to do a whatever kind of repair, I want
6 you to know that this type of surgery has some kind of risk

7 to it. There's a risk of infection, there's a risk of
8 nonunion. There's a risk of delayed healing. You might get
9 a recurrence. Gee, if you're having anesthesia, general
10 anesthesia, you could die from it. You'd go through the
11 whole panoply. Mr. Pillersdorf likes that word. You'd go
12 through the whole panoply of risks. And when the patient
13 understood the risks you would feel that you had done your
14 job of explaining risks, right?
15 A Yes.
16 Q But to obtain an informed consent, you'd also talk
17 to the patient about what alternatives there were, right?
18 A Correct.
19 Q Now, sometimes you might have a definite opinion
20 about whether a condition is amenable to any treatment other
21 than surgery, right? There are some conditions where your
22 opinion is surgery is the best choice for this person, right?
23 A Correct.
24 Q And if that's your opinion, that's what you would
25 tell the patient, right?

1 A As well as there are other options. Just to be
2 complete.
3 Q Right, right. But you would make a recommendation.
4 You're not there to be a neutral observer. You don't work
5 for the United Nations. You're there to tell the patient
6 what you think their best shot is, correct?
7 A Correct.
8 Q Oh, you might say to them, listen, there's an
9 alternative, you can sit in a cast for two months. I can
10 immobilize you in a Cam Walker, but I don't think it's going
11 to work?
12 A Correct.
13 Q And if that's your belief, if that's your opinion,
14 if that was your best judgment, then it's not a departure to
15 tell the patient that's the way you see it, right?
16 A Right.
17 Q Now, it may be that using your best judgment guided
18 by years of experience, you turn out to be wrong. That
19 happens sometimes, right; you're a human being, right?
20 A Right. The results of surgery are not 100 percent
21 predictable.
22 Q Even in Virginia surgeons occasionally make
23 mistakes?
24 THE COURT: I'm not going to tolerate you ascribing
25 that to my home state, okay.

1 MR. HELLER: Okay. I didn't know that. You gave
2 me some rope and I just --
3 A You got it, correct.
4 Q So you couldn't have been from North Carolina, huh.
5 Assuming that you gave the patient your best
6 judgment, your recommendations after years of experience and
7 giving it your best thought and you really analyzed it, you
8 could still be wrong on occasion, right?

9 A Absolutely.
10 Q And that doesn't mean you committed malpractice,
11 does it?
12 A No.
13 Q Doctor, over the years you've done lots of
14 surgeries, yes?
15 A Yes, sir.
16 Q And on some occasions you've done maybe a bunion or
17 a heel spur and you've wound with a postoperative infection,
18 right?
19 A Correct.
20 Q And you recognized the infection, you treated it
21 appropriately, right?
22 A Right.
23 Q That's not malpractice, is it?
24 A No.
25 MR. PILLERSDORF: Objection; it's irrelevant,

1 your Honor.
2 THE COURT: Overruled.
3 Q There are complications to every surgical procedure
4 that one could think of, right?
5 A Absolutely.
6 Q And there isn't a surgeon in America that is
7 totally free of any complication if they've been doing
8 surgery for 20 or 25 years, true?
9 A Correct.
10 Q When Dr. Lombardi discovered that he believed
11 Miss Licitra had a foot drop, he didn't attempt to hide it,
12 did he?
13 A No.
14 Q He wasn't an ostrich; he didn't stick his head in
15 the sand and say, well, use a crutch for another couple of
16 weeks, let's try a different orthotic or anything like that,
17 right?
18 A Correct.
19 Q He said get thee to a neurologist, right?
20 A Right.
21 Q I think you have a problem, go to a neurologist,
22 right?
23 A Correct.
24 Q That was the appropriate thing to do, right?
25 A Absolutely.

1 Q Surgeries get scheduled, surgeries get cancelled
2 for reasons that sometimes you're not even aware of, right?
3 A Absolutely.
4 Q You have an office with four doctors?
5 A Yes, sir.
6 Q And does somebody manage your patient load, your
7 ordering of supplies, your billing of health care fees and
8 all that stuff?
9 A Yeah, we have individuals that have different jobs,
10 that's true.

11 THE COURT: It's 4:10.
12 Q Sometimes you schedule a patient or you recommend
13 surgery, the patient agrees, and you send her to your
14 scheduler, and they set up the surgery, right?
15 A Right.
16 Q And it's added to your surgical schedule, right?
17 A Right.
18 Q And your office probably hands you a piece of paper
19 every week for the next week's surgeries?
20 A Correct.
21 Q And it happens from time to time that a name may be
22 deleted from the list, right?
23 A You hope not.
24 Q Well, I mean somebody cancels a surgery, it
25 happens?

1 A Oh, sure, in that situation.
2 Q I don't know, somebody dies.
3 A I thought you meant their name didn't make the list
4 and they're supposed to have surgery.
5 Q No, I mean somebody cancels a surgery.
6 A Correct.
7 Q There could be a million reasons for that?
8 A I never question it.
9 Q And you don't investigate it?
10 A I'll ask.
11 Q Why did Mrs. So-and-so cancel the surgery?
12 A Correct.
13 Q You always ask?
14 A Absolutely.
15 Q And do you always get an answer that makes sense to
16 you?
17 A Mostly, yes.
18 Q Is the answer sometimes the patient called and
19 cancelled, period?
20 A We're typically asking for a specific reason.
21 Maybe they had a death in the family or maybe they didn't get
22 their medical clearance or they decided against it. Just to
23 be fair and understand if there's a reason they might be
24 upset with our office.
25 Q But maybe they don't tell you why?

1 A That could happen.
2 Q And is it of critical importance if whether the
3 patient cancelled because Uncle Harry's car broke down and
4 they don't have a ride to the hospital, or because the dog
5 died, or because their kid is graduating from high school and
6 they couldn't do it, right?
7 A Well, I just think it's important to have the
8 reason known to me.
9 Q Right. But if one of your patients cancels a
10 surgery and reschedules it, it doesn't mean you or your
11 office did something wrong, does it?
12 A No.

13 MR. HELLER: Doctor, thank you very much.
14 THE WITNESS: You're welcome.
15 THE COURT: Redirect?
16 MR. PILLERSDORF: Yes, Judge.
17 MR. HELLER: I'm just going to move my stuff over
18 here off the lectern.
19 MR. PILLERSDORF: I don't know if I can complete in
20 three minutes. Can I have a second to talk to the
21 doctor about his availability in the future?
22 THE COURT: I'm sorry? Five minutes, members of
23 the jury. Quickly.
24 COURT OFFICER: Okay, jurors, upstairs.
25 (Whereupon, the jury exited the courtroom; a recess

1 was taken.)
2 THE COURT: We're ready.
3 COURT OFFICER: Jury entering.
4 (Whereupon, the jury entered the courtroom.)
5 THE CLERK: Do both sides stipulate the jury is
6 present and properly seated?
7 MR. HELLER: Yes.
8 MR. PILLERSDORF: No. Yes, I do.
9 THE CLERK: Thank you. You may be seated.
10 THE COURT: Welcome back.
11 MR. PILLERSDORF: It's Friday.
12 THE COURT: Moving straight ahead.
13 REDIRECT EXAMINATION
14 BY MR. PILLERSDORF:
15 Q Doctor, according to the chart and the record in
16 this case, on August 18th, when the patient was examined
17 preoperatively by Dr. Lombardi, she did not have a drop foot;
18 is that correct?
19 A Correct.
20 Q The first time she walked immediately after the
21 surgery or ambulated immediately after the surgery he saw a
22 drop foot; is that correct?
23 A That is correct.
24 Q All right. She told us that the doctor told him
25 that while this surgery was pending there was no tennis. So

1 assume that we have no tennis from before the operation until
2 the drop foot. Tennis didn't cause the drop foot, did it?
3 A Not in my opinion, no.
4 Q She has hideously ugly hammered nails, screwdriver
5 saw toes, all right, is that correct? Vargus, valgus, tugas,
6 whatever she had.
7 A I'm not going to characterize it. She had bunions
8 and hammertoes.
9 Q Bunion hammertoes, all right, as bad as my
10 skeleton, upon which the germ-a-phobe wouldn't touch my
11 skeleton. He brought his own.
12 That doesn't cause drop foot, does it?
13 A No.
14 Q The lady has been playing her little tootsies off

15   with tennis, but she had been playing tennis three times a
16   week for hours, whatever it was, and in August and in June --
17   June 20th, August 18th, and a couple of days before, no drop
18   foot?
19   A   Correct.
20   Q   Okay. So now, something happened in between to
21   cause the drop foot; is that fair?
22   A   Yes.
23   Q   Arthur Ash didn't beat her with a stick? She had
24   drop foot that came from the surgery; you agree with that?
25   A   That's the only logical answer, in my opinion.
0463
 1   Q   The operation --
 2   MR. HELLER: Will he stop leading, your Honor.
 3   MR. PILLERSDORF: Oh, sit down.
 4   THE COURT: You didn't hear that, members of the
 5   jury. Levity, aside, avoid the leading questions,
 6   Counsel.
 7   Q   His surgery, flipping the tendon, cutsy, whatsy on
 8   the lateral side of the foot, the surgery itself, the repair
 9   of the tendon, the rehooking it around, the fixing the bone
10   on the calcaneus, that doesn't cause drop foot, does it?
11   A   No.
12   Q   So there's nothing about the surgical procedure,
13   she didn't have it before, she had it after.
14   Let's go back to the cast. The neurologist that
15   she was sent to by Dr. Lombardi immediately after his
16   discovery that she had a drop foot, he said she has drop
17   foot; is that correct?
18   A   Correct.
19   Q   In his report of his options and differential, he
20   said that it was either surgical position or the cast; is
21   that correct?
22   A   Correct.
23   Q   Dr. Lombardi told us that the position shouldn't
24   cause a drop foot. You know the position, all right; the
25   patient is on pillows and what have you with the dorsal side
0464
 1   exposed. That shouldn't cause a drop foot, should it?
 2   MR. HELLER: Objection.
 3   A   No.
 4   MR. HELLER: What are we talking about?
 5   MR. PILLERSDORF: The lateral side. He
 6   understands.
 7   A   Well, I want the jury to understand. What
 8   they're saying is for this surgery Dr. Lombardi placed the
 9   patient with her right foot down so the left foot is up.
10   So there's no pressure on the side of the foot. There's
11   no pressure in the common peroneal area that would result
12   in the drop foot.
13   Q   So we're still back to the cast; is that correct?
14   A   Yes.
15   Q   Mr. Heller was talking about a silly machine that I
16   couldn't get to work earlier, I'm not. But he correctly

17 pointed out that it makes a mess. I don't want to say a
18 mess. It's noisy?
19 A It's -- you can't carry on a conversation it's so
20 noisy.
21 Q And in the recovery room, in general, you don't get
22 your own recovery room in a hospital, do you? Recovery rooms
23 are where patients from the different ORs, whether it's room
24 two, whether it's room one for the cheaper seats, patients go
25 into recovery rooms; is that right?

1 A Recovery room is in general an open area with the
2 only separation between patients being pricey like curtains.
3 Q Okay. So this kind of thing is usually done --
4 you've indicated it doesn't have to be done, but it's usually
5 done if you're going to cut the cast and split the cast,
6 that's done in the operating room; is that right?
7 A I would assume that's where it would be done.
8 Q It makes sense to do it that way?
9 A Correct.
10 Q If we were told by the nursing staff that
11 Dr. Lombardi -- and their recollection is he always does his
12 own work, he's very hands on, all right, and every time the
13 nurse -- and we'll now hear the nurse next week. But every
14 time the nurse, hundreds of surgeries, you were quoted from
15 it before, nursing said he always does his own casting and
16 his own cutting, that would be appropriate; is that fair?
17 A That was her testimony, and that's appropriate.
18 Q Yet, in Dr. Lombardi's note, in this note, in this
19 case he says if somebody did it, it's the resident?
20 MR. HELLER: Objection to the form of the question,
21 your Honor.
22 Q Doctor, when someone says resident split cast, when
23 you're a physician and when you say resident split cast, am I
24 correct in assuming that that means that the doctor didn't do
25 it? When he said the resident did it that means, that the

1 doctor didn't do it?
2 A Correct.
3 Q So this note that we've had read, all right, cast
4 intact. Intact is a word that means in one piece?
5 A Correct.
6 Q We know it's a cast and we know that the doctor
7 wrote that he saw it intact?
8 A Correct.
9 Q We don't know who put it on, but he's knows it's
10 intact. Then it says split resident, split by resident, it
11 means he didn't split it; is that correct?
12 A Exactly.
13 Q If a resident came in here and said I don't
14 remember, but Dr. Lombardi always splits them, we've got a
15 problem, don't we? Let me move on?
16 A Correct.
17 Q In a note written after he's aware there's a
18 lawsuit, or going to be a lawsuit, after he was aware that

19 the patient has a problem, all right, after he's been asked
20 for his records and he figured out --
21 THE COURT: Question.
22 Q -- they don't want my records.
23 MR. HELLER: Objection, your Honor. It's also an
24 improper redirect. I didn't go there on cross.
25 THE COURT: Sustained.
0467
1 Q Doctor, in this case, the surgeon's own office
2 notes say the cast was cut by the resident; is that right, if
3 cut?
4 A Correct.
5 Q With this woman's -- withdrawn.
6 You've been through all sorts of records, prior
7 podiatry records, post podiatry records, her neurologist
8 records, Dr. Applebaum's records?
9 A Correct.
10 Q The drop foot, in your opinion, did it come from
11 compression caused by the cast?
12 MR. HELLER: This is a leading question,
13 your Honor.
14 THE COURT: What's your answer?
15 This is the last question, correct?
16 MR. PILLERSDORF: Two, two more.
17 THE COURT: Answer.
18 A Yes.
19 Q Drop foot could not and would not happen if the
20 cast had been cut; is that correct?
21 MR. HELLER: Objection.
22 THE COURT: Sustained.
23 MR. PILLERSDORF: Why? What's wrong with that one?
24 Is that leading?
25 Q Can you get drop foot if the cast had been split?
0468
1 A Theoretically, you could. I mean, if you really
2 think about it, because the bandages could, but typically no.
3 Q If a cast is properly split.
4 A You shouldn't.
5 Q She has drop foot?
6 A Correct.
7 Q There's no question about that, all right.
8 Now, people with drop foot can, by doing muscle
9 work, by lifting, by walking funny, they can compensate for
10 that; is that fair?
11 A Yes.
12 Q Could play tennis, lousy, but could play if they
13 really wanted to?
14 A Depending on how much muscle strength or their
15 abilities, sure, they could try to play.
16 Q Could someone with a drop foot -- we've seen her
17 walk. She can walk?
18 MR. HELLER: Objection.
19 THE COURT: How many questions?
20 MR. PILLERSDORF: Judge, I appreciate it and you

21 said I had 4:30. I got four minutes. You're not going
22 to cut my four minutes?
23 THE COURT: Question.
24 MR. PILLERSDORF: Thank you.
25 Q Doctor, a drop foot, all right, is not death.
0469
1 People can get around with them; is that fair?
2 A Yes.
3 Q With passage of time people compensate for their
4 weakness in the drop foot?
5 MR. HELLER: Objection. This is leading.
6 THE COURT: Sustained.
7 Q People compensate --
8 THE COURT: Sustained.
9 Q Doctor, can you train -- can a patient be trained
10 or be rehabilitated when they have a drop foot?
11 MR. HELLER: Objection, your Honor.
12 THE COURT: Overruled.
13 Please answer.
14 A Yes.
15 Q With wearing orthotics, they don't all look like
16 this, do they?
17 A No.
18 Q Mr. Heller showed you one, all right. He shoulder
19 you the air cast. Those are sort of two extremes. There are
20 all sorts of devices to help -- withdrawn.
21 Are there various sources to help people with drop
22 foot?
23 A Yes.
24 Q To help you with the dorsiflexion. Some of them
25 provide more mobility than others; is that fair?
0470
1 A Correct.
2 Q When you talk about the gait, the problem with the
3 drop foot is you've got to somehow get your foot up high
4 enough so you don't trip; is that fair?
5 A That's the easiest way to think about it.
6 Q All right. And if the ground is flat, for
7 instance, this courtroom is, on the record, perfectly not
8 free of defects, all right, a person with a drop foot even if
9 they're dragging it can handle it; is that fair?
10 A Yes.
11 Q Okay. With bumps, all right. They have to do
12 other things. They have to pull the knee up. They can do it
13 from the hip. There are lots of ways. You just have to get
14 the leg above the height of the impediment; is that fair?
15 MR. HELLER: Objection. Who is testifying, Judge?
16 THE COURT: Sustained. Disregard the question,
17 members of the jury.
18 Now, rephrase it properly, Counsel. We're not in
19 that big a rush.
20 Q Positioning -- withdrawn.
21 Doctor, the mechanics of the drop foot is the
22 plantar, the drop towards the plantar side, it's falling

23   down, right?
24   A   Yes.
25   Q   There are things you can put in your shoe that will
0471
 1   at least keep it level; is that right?
 2   A   Correct.
 3   Q   There are L-shaped, there are big ones, there are
 4   little L-shaped orthotics that will keep it?
 5   A   Correct, as you could see here.
 6   Q   All right, these different ones. And with these
 7   the people can walk with very little limitation; is that
 8   true?
 9   MR. HELLER: Objection, your Honor, leading this
10   witness.
11   Q   What's the impact of these things on the mobility
12   of the patient?
13   A   They help the patient to walk more normally.
14   Q   Okay. A physician can spot a drop foot?
15   A   We call it a gait analysis, watching somebody walk.
16   If you have a trained eye, you typically will pick it up.
17   Depending on how much weakness there is, I could say a doctor
18   could miss it.
19   Q   If they're wearing a good orthotic, L-shaped
20   orthotic and you can't see the orthotic, it's under the pant
21   leg, is it then almost imperceivable (sic)?
22   A   It can be.
23   Q   So we can help people with drop foots. Pain --
24   MR. HELLER: Objection. It's not a question.
25   Q   Doctor, you reviewed the records. Along with the
0472
 1   disability and the dysfunction of her leg, the drop foot, she
 2   also had pain; is that correct?
 3   A   Correct.
 4   Q   All right. The pain, you followed Dr. -- the
 5   neurologist, all right, Dr. Caprarella, you followed her,
 6   she's still following her; is that right?
 7   A   Yes.
 8   Q   Throughout those reports, the movement, the
 9   control, the muscle has varied over the years; is that fair?
10   A   Correct.
11   Q   Has the pain been consistent?
12   A   Yes.
13   Q   Has the pain been constant?
14   A   Yes.
15   MR. HELLER: Objection, your Honor. This is not a
16   direct examination. I mean, this is leading. He's not
17   cross-examining the witness.
18   THE COURT: That was your last question?
19   MR. PILLERSDORF: Yeah, you know what, I'll sit
20   down.
21   Doctor, thank you. Have a safe trip back.
22   THE WITNESS: You're welcome.
23   MR. HELLER: May I have two, just one?
24   THE COURT: Okay, try for one.

25 MR. HELLER: Try for one.
0473
1 MR. PILLERSDORF: Then do I get a half?
2 RECROSS-EXAMINATION
3 BY MR. HELLER:
4 Q Doctor, if you saw a person walk down the street
5 and they didn't have an ankle foot orthoses, they didn't have
6 a brace, they didn't have an appliance, they just had a pair
7 of shoes and they walked normally, would they have a drop
8 foot, in your opinion?
9 A If it looked normal, I'd have to assume they don't.
10 MR. HELLER: Thank you.
11 THE COURT: You may step down.
12 THE WITNESS: Thank you.
13 THE COURT: Members of the jury, you have worked
14 exceedingly hard today. Thank you very much. Have a
15 very, very good weekend, and I tell you, follow the
16 rules, particularly as it relates to talking about the
17 case. And you may be tempted because of what you've
18 heard today to go on that computer. What did I tell you
19 about that?
20 THE JURORS: No computer.
21 THE COURT: Say it louder.
22 THE JURORS: No computer.
23 THE COURT: Have a good weekend.
24 Clerk Dougherty?
25 THE CLERK: 9:30.
0474
1 THE COURT: 9:30 Monday morning we will see you.
2 Thank you, Counsel. Have a good weekend all.
3 MR. HELLER: You too, your Honor.
4 (Whereupon, the proceedings were adjourned to
5 Monday, April 26, 2010 at 9:30 a.m.)
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25